Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 201 Tear 6:46 AM John E. Soffa, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 🖾 M 2 🗆 F Days Hours Months Pennsylvania 191 Director 160-05-8841 93 Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Tes 2 No PA Montgomery East Greenville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1389 Taggart Road 18041 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give ו "natural", or item ledical Examiner וו Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed d 2 should be filed within 72 hours a alth and Mental Hygiene.

127 is marked other than "natural or traumatic event, the Medical E. Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pipe Fitting/Mfg. Elementary/Seconday (0-12) College (1-4 or 5+) Molder Stanley G. Flagg Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Andrew Soffa Mary Ivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1389 Taggart Rd., East Greenville, PA 18041 Geraldine F. Soffa (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holy Cross Cemetery Pennsburg, PA 11/7/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mann-Slonaker Funeral Home, Inc. 222 Washington St., East Greenville, PA 18041 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) tenosis Physician/ ortic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No į Day Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? page 2 performed To the Hospital or Attending Physician: The within 42 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

7600 Carroll Ave., Takoma Park, MD 20012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

James K. Lighfoot, Jr. MD

31. Date filed (Month, Day, Year)

November 2, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:35P JOSEPH A. SOBRIO NOVEMBER6. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE TOWSON If Unc 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 218-28-0956 **Director** 1 X M 2 🗆 F 91 Yrs FEBRUARY 14,1920 ITALY Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD. BALTO. TIMONIUM 1 Yes 2X No 10e Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral items 23a 21093 2114 POT SPRING ROAD USA death v 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. ò by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: WHITE Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Secondary (0-12) 6TH College (1-4 or 5+) SELF-EMPLOYED PAINTING CONTRACTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill timent of Health and Mental tant: If item 27 is marked ပ JOHN SOBRIO ANNA Patti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md. 21236 DTR. Unit2F 4102 Chardel Road Grace Sobrio 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 11-11-2011 Balto.Md. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home. Inc. 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease. implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.

Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months? ō Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) filled in by the funeral 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending 1 Yes 2 No after death. Director: A Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier NO VEOU ber Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUES MM 6701 Charles

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		4 Donation	5 Other (Special			TIMORE	HEB	REW C	EM. 1	1/9,	/2011	R	EISTE	RST	OWN, M	D
Bal	permit Depar Impor any in		21. Signature of Fur	neral Service ticens	the		100		nd Address			LEVIN					.08
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locat City of									cation (Street and Number or Rural Route Number, ty or Town, State)				er,		
	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2	Medical Exami	sician: To the best of oner: On the basis of exercising Practioner: To the	kamination	n and/or invest	igation, in r	my opinion,	death occur	rred at t	he time, date a	nd place.	and due to	the caus	se(s) and mar	ner stated.
	To t with To t		29b. Signature and t		00) L		29c	. License n				29d. Date	e signed (N	onth, D		(1
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 320bsc per flyand bepartment of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 7011 GIVENS IEMUEL 1734 pm NOV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENERAL COUNT COLUMBIA Hounds MC 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 425-80-2788 Director 1 M 2 🗆 F 2-13-M1851551 PP1 28a-f show 10c. City, Town or Location must be notified at **Funeral Director** 1 XYes 2 □ No CLARKSYILL ō 10g. Citizen of What Country? 23a COURT 21029 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No "natural", Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) and Mental F 2 UNK permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THERINE TAXLOR Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gteensboyd worth Donation 5 Other (Specify) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Physician/ ALUTE disease or condition Medical resulting in death) **Examiner** ENEWA TATIT ulmanor if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin HYPERTENSION burial-trar attending physician and for use as the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law cate has I autopsy performe this certificate 2 🗌 No 1 🗌 Yes After this certification of funeral director, p Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မ 1 Inpatient 2 YER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 1 Matural 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpletely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Gertifying Nurse Practition of: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NN 2011 D50538 30. Name and address of person who completed/cause of death (tem 23a) (Type, Print) Mulalich 31. Date filed (Month. Day, Year) Registrar's Signatur State NOV 10 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #14 Per FH G921 11/15/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Nancy Lynn White 11 2011 2:00 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8891 Old Scaggsville Road Howard Laurel 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea **Funeral** Days Hours 220-60-1225 Director 1 🗆 M 2 🗶 F 57 1954 02 North Carolina Usual Residence of Deced 10c. City, Town or Location at Director notified 28a-f 1 Yes 2X No Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n ms 23a or must be r Funeral 20723 8891 Old Scaggsville Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14 Race - American Indian 'natural", or ite dical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No 21215-0036 BLACK WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NASA 12 years Computer Analyst Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Carey Cale Irma Lee Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda White - DAUGHTER Department of Health Important: If item 27 any injury or other tr 801 Kay Court #202 Laurel MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC 11-10-2011 Baltimore, Maryland Signature of Puneral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore MD 21228 23a. Part 1. Enter the disease, or complications that caused the depth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ung Metastatic disease or condition Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery Box (3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Hospital Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at work? ie Hospital or Attending P n 24 hours after death. ie Funeral Director, After t Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year, 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61067 November 10 Physician (MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12520 Prosperity Drive Suite #320, Silver Spring MD 20904 Laura Khanbadle 32. Registrar's Signatur 31. THOUGH Morth, 2014 ar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Blanche November 8, 2011 Ε. Wolpert 8:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6125 Deerbrook Road Baltimore Catonsville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 6, 1924 **Funeral** 9. Birthplace (State or Foreign Days Hours Maryland Director 213-20-8824 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10c. City, Town or Location Director notified 1 Yes 2 1 No MD Baltimore Catonsville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 6125 Deerbrook Road 21228 USA and 2 should be filed within 72 hours after death 1 Health and Mental Hygiene. Fem 27 is marked other than "natural", or items ther traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Wieber Cassandra Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton A. Wolpert Husband 6125 Deerbrook Road; Catonsville, MD 21228 item 2 20a. Method of Disposition 20b Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 11/15/2011 Garrison Forest Owings Mills, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ TI disease or condition week Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> SEIZURE DOSORDER, HYPERTENGEON, 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? of or Attending Physician: The safter death.

Director: After this certificate is 1 ☐ Yes 2 ☐ No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

To the Funeral D Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Berches D22114 november 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMDAN & BLECKESS
5 411 OLD FREDFRICK RD SULFER, BRLYLMOR, MD. J1339 BERCHESS MO

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ State	of Maryland	-	ent of H			giene Reg. No. 20	36007	
Physicia	an	Registrar Decedent's Name (First, Middle, Last) Ronald Frank Wuensch	mell, Jr.	0011111			2. Date of De		3. Time of Death	
/Medic Examina Funeral Director	al	4a. Facility Name (If not institution, give street and School Sch	number) 70 HOSD 7. Age (In yrs. la	ital	Balt nder 1 Year	Location of Death MONE If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	of Death 9. Birthplace (State or Foreign Country) Pennsylvania	
death with the Maryland ms 23a or 28a-f show rmint be rediffed at	or	Usual Residence of Decedent 10a. State 10b. County		Town or Location					10d. Inside City Limits †▼ Yes 2 □ No	
23a or 28a-f ust.be notifis	Director	MD 10e. Street and Number	Bal		f. Zip Code			10g. Citizen of V	21	
Examiner m	by Funeral	1 ☐ Never Married 2 ☒ Married 1 ☐ Y	Decedent Ever in U.S d Forces? es 2 XNo , Give or Dates:	. 13. Was D	21214 Decedent of Hispecify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		e - American Indian, k, White, etc. /: White	
	Completed	8	ted) ge (1-4or 5+)	16a. Decedent's (Give kind of life. DO No Contrac	of work done d OT use retired,	ation luring most of work) 18. Mother's Nam		Home In	nprovements	
	To Be	17. Father's Name (First, Middle, Last) Ronald Frank Wuenschel	.1			Betty Je				
		19a. Informant's Name/Relationship (Type. Print) Patricia A. Wuenschell 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal for 4 Donation 5 Other (Specify)	State, Zip Code) 214 City or Town, State							
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	MO12! nat caused the death, on each line. PXI3 e to (or as a consequence of the line) Fig. PVI e to (or as a consequence of the line) glowmydd e to (or as a consequence of the line)	Going 51 Beve: Do not enter the ence of): WORLY Elice UI).	rly L. mode of dying	Crematic Heckrott g, such as cardiac	P.A.	Clarks	Box 784 Willo, MD 21020 Approximate Interval Between Onset and Death MOVICS	
	Physician/Me	1	, outcome of pregnar Live birth 2 ☐ Fetal Pregnant at time of de Jnknown	death 3□Ecto eath 5□Otho	opic pregnancy er (specify)		23d. Date of delivery Month Day Year If tobacco use contribute to the cause of death			
		Part II. Other significant conditions contributing	en in Part I.		Yes 2 No	3 Probably 4 Unknown				
	Completed by						perf 1 □ Yes	opsy ormed? 2 No	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
	Certification: To Be									
		4 Homicide determined 29e. F	Place of Injury - At hor building, etc. (Specify to the best of my know	vledge, death occ	urred at the tir	me, date and place	City or To	e cause(s) and m	ber or Rural Route Number,	
	Medical	(Check only 2 Medical Examiner: On	the basis of examinat manner stated.	ion and/or investig	ation, in my o	pinion, death occu	urred at the time	e, date and place,	and due to the cause(s) ed (Month, Day, Year)	
			, M	1. p -	PES			. /	ber 8,2011	
Star		30. Name and address of person who completed Khimber Ry D. Saw 31. Danied (Monte Say, Year)	cause of death (Item) -	Novem	Der 8,2011 	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan		rtment tificate				_	20		360	0.8
			Registrar 1. Decedent's Name (First, Middle, L	ast)		001	incate	OI D	Catif	2. Date of De				3. Time of Deat	
	Physicia Medic		JAMES MELVIN WRO					Month NOV	03	20		10:43 P	М		
	Examin	er									1	County of E		D.77	
_	Funeral		WRNMMC 5. Social Security Number 6.	If Under 1		If Under 24 Hrs.	8. Date of Birl	h	MONTG 9.	. Birthp	lace (State or Fore	∍ign			
	Director		506-24-3389	1 🛛 M 2 □ F	82	Yrs.	Months	Days	Hours Min.	Feb. 2	, Year 9 2	29 No	ebra	iska	
	and show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or										10	Od. Inside City Lim	nits
	Maryla 28a-f	irect	Virginia Lancas	te Stor	1e					1 ☐ Yes 2♣ No			No		
	th the 3a or t be n	al D	10e. Street and Number 286 Breezy Point		10f. Zip Code 22578				10g. Citizen of What Country? U.S.A.				1		
	eath wi	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S	5. 13. V			panic Origin? (Spe , Mexican, Puerto	cify Yes or No-		14. Race - /	America	an Indian,	\dashv
36	filed within 72 hours after death with the Maryland al Hygiene 1 other than "natural", or items 23a or 28a-f sho 1 other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	by	1 Never Married 2 X Married	Armed Forces? 1 A Yes 2 If Yes, Give	No	- 1	Yes, specify		Mexican, Puerto Specify:	Rican, etc.)		Black, V	White, e	tc.	
ö	atural	Completed	3 Widowed 4 Divorced If Yes, Give Year or Dates.			16a. Deced						Specify: \			
215	in 72 h e. han "n	Jup	(Specify only highest Elementary/Seconday (0-12)	5+)	(Give k	ind of work NOT use re	done du	ring most of worki	ng		b. Kind of Business Industry				
21	d with tygien ther th	Be C		5+		B1	rigadi		General		_	S. Arı	my		
auc	be file ental F rked o ic eve	TOE							Reba Sha		Maiden S	urnarne)			
lary	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It had Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	- 9	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 286 Breezy Point, White Stone, VA 22587								e, Zip C	ode)			
დ `	and 2 s Health lem 27		Molly Mullan Wro	oth (Wife)											_
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		, C	lace of Disposemetery, crem	atory or oth	er place,	Nov. Nov.		11	cation - Cit	-	_{wn, State} rginia	
a E	rmit. P spartm portar y Injur		21. Signature of Funeral Service Lice		INOL									Iginia	
m	a m B De	99	Butan)1284				eral Home 275, Kil			2248	2		
ı,	Of		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death												
	h sician/ Medical		disease or condition resulting in death)	a. MARGII Due to (or as			YMPHON	MA					-		\dashv
	Examiner	<u>.</u>	Sequentially list conditions, b.												
	red	Examiner	if any, leading to immediate Due to (or as a consequence of): outes. Enter Underlying Cause (Disease or linjury												
	execui an and rial-tra	I Exa	that initiated events c. Due to (or as a consequence of):									 			
90	cate be executed physician and the burial-transit	edical	•	d									+	-	
687	certific nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						-		23d. Date o	of delive	erv	
Вох	death of	Physician/M	in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Other (spec					Month		Day Year	
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ord	w requ	plete								24a. Was		24b. Wer	ere autopsy findings available or to completion of cause of		able
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ta	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Other	ce of Death (Chec			-			
of <	g Physer this er this eral di	te: To	27. Manner of Death	28a. Date of inju	ıry	ER/Outpatien 28b. Time of		a. Injury	_4 ∐ Nursing Ho at	ome 5 Resi 28d. Describe			Specify)	
o	tendin leath. or; Aft the fur	Certificate:	1 X Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not		y, rear)	injury	М	work?	∕es 2 □ No						
Division of Vital	lor At after c Direct Jin by	Cert	4 Homicide determine				et, factory, o	office		28f. Location (City or Tou			or Rural	Route Number,	
	ospita hours uneral ed fillec	Medical	29a. Certifier 1 X Certifying PI	ysician: To the best of	my knowl	edge, death o	ccured at th	ne time,	date and place, ar	d due to the ca	ause(s) and	d manner a	as state	d.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me		miner: On the basis of e urse Practioner: To the			eath occurre	ed at the	time, date and place		ne cause(s)) and mann	er as st	ate d .	stateu.
	★≥₽ 8		A A A A	120				License				e signed (A 4, ZC		Jay, rear)	
	•		30. Name and address of person who	completed cause of c	leath (Item	23a) (Type, P	LVA	01	01249686)	1 X	1/20	/ L f		
y .			CTCELY ANNE DYF 31. Date filed (Month, Day, Year)	I.T MD 32 Registr	ar's Ciana	ura	WRN	MMC.	BETHESI	DA, MD	2088	39 560	00		
	Stat Registra		31. Date filed (Month, Day, Year)	011 Drew	ar s oignat	1. La	Mes								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2011 arol 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 16 Fusting Avenue Raltimore Catonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day. Year. 1 M 2 XX 13 217-14-6505 Director 1924 Maryland Jan. Usual Residence of Decedent 10d. Inside Cify Limits 10b. County 10c. City, Town or Location Item 27 Is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, "he "he did a form net must be notified at 28a-f show 1 ☐ Yes 2XXVo Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16 Fusting Avenue 21228 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2XXXVo Specify White à 3 XXVidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 end 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Greinus Carolyn Wehrenberg ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert G. Sparrow, Jr. 1137 Mount Drive, Pasdena, Maryland 21122 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Kerial 2 Cremation 3 Removal from State St. Paul's Cemetery Nov. 10,2011 Violetville, Maryland 4 ☐ Ponation 5 ☐ Other (Specify) 21. Sign ture of Funera 22. Name and Address of FacilityAMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** There's dero bi Cardiovasina /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Daw to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? certificate 1 □Yes 2 DN 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Starting Home 5 Residence 6 Other (Specify) 1 Tes 2 De Yo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 47683 8/11

Registrar DHMH 17 Rev 1/2001

State

2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835

31. Date filed (Month, Day, Year)

1 0 2011

Smith

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03: LSAM HELEN WHALEN NOVEMBER 09 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Days 226965 Director evenber Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leatth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 No Director MARY BUB 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 🗌 Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) UWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Kose 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 a
Department of Hes
Important; If item
any Injury or othe 20a. Method of Disposition 20c. Location - City or Town, Stay 1 Burial 2 Cremation 4 Donation 5 Other (Specify) ChoTNACK: FINELAL HOME 21. Signature of Funeral Service Licenses 1005 DUNDAIK AVE BATTIMORE Part 1 Part 1. Inter the disease, or complication and at caused a shock, or heart failure. List only one call e on each line. Approximate Immediate Cause (Final SEPTIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year P.O. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, FIBRILLATION 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 Z N 1 Tes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury 2 No 1 TYes 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier (check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D69660 NOVEMBER 09,2011 nd address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001
11595

State

4940 Eastern Avenue, Baltimore, MD, 21224

M. EZE-NLIAM, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 3, Physician/ 2011 Daniel 11:40 Max Zolotorofe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 Months Days Hours Min. New Jersey March Day Yea 199 20 Director 134-78-1772 Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Bergen Mahwah 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 161 Stephens Lane 07430 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Student Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Zolotorofe Jill Goldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 161 Stephens La., Mahwah, NJ 07430 David Zolotorofe (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🕅 Barial ☐ Cremation 3 ☐ Removal from State Cedar Park Cemetery 11/6/2011 5 Other (Specify) Paramus, NJ 4 Donation ture of Juneral Service Livinsee 22. Name and Address of Facility Robert Schoem's Menorah Chapel. Inc. 150 W. State Rt 4 Paramus, NJ 07652 21. Sig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition Onset and Death Physician, Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 performed After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural (Month, Day, Year) 5 Pending after death. 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

title of certifier

Piot Wyrwinski, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

29b. Signature an

31. Date filed (Month)

32. Pegistrar's Signature

29c. License number

7600 Carroll Ave., Takoma Park, MD 20912

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Louise 5:10 P October | Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles Charles County Nursing & Rehab Center Waldorf 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, 1 ☐ M 2 🙀 F 90 193 22 5011 1921 **Director** New Jersey Usual Residence of Decedent 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 XXNo Waldorf <u>Maryland</u> Charles 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral United States 20603 10705 Alyssa Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 🙀 Widowed 4 🗌 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Maintance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trau 10705 Alyssa Lane, Waldorf, MD 20603 Benjamin Ashe (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) 10/29/2011 Carnegie, Pa Chartiers Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 663301d Alexandria aneral Service Licensee 21. Signature Clinton, MD 20735 Ferry Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line bladder cascinoma Onset and Death Immediate Cause (Final disease or condition Physician/ Meta Medical resulting in death) **Examiner** D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran ed by the attending physician detached for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Year in the past 12 months? Day 2 No 9 18 Unknown After this certificate has been signed by funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by Diabeter mellitur. Araemia 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 2 🗌 No Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 71199 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. 305 in Vonhapilly IND, 2007 Tide Wol WlonyDrive 1A, Annoyotis, 3DC 31. Date filed (Month th, Day, Year) 32. Registrar's Signature State 6

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER ASHTON 8:10 AM MARY SUE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRADFORD OAKS CENTER CLINTON PRINCE GEORGES . Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min. VIRGINIA **Director** 91 FEBRUARY 226-26-3518 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1X Yes 2 ☐ No MD PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 20772 12907 RHINE RD. USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates BLACK 3X Widowed 4 ☐ Divorced and Mental Hygiene.

is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC 7TH PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andre,
wit. Page 1 and 2 shc.
"ent of Health and Ne.
"item 27 is marked v.
"traumatic evr 2 ROY FLORENCE DAVIS JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHANIE JOHNSON / DAUGHTER UPPER MARLBORO, MD 20772 12907 RHINE RD., permit. Page 1 and 2 Department of Health Important: If item 21 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/14/2011 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT'L CEM. ARLINGTON, VIRGINIA 21. Signature of Funeral Service Lice 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 716 KENNEDY ST. NW, WASHINGTON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ **ALZHEIMERS** disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PARKINSON'S DISEASE Sequentially list conditions, cause. Enter Unique Classes (Disease or linjury Due to for as a consultience of Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Month 4 Pregnant g Unknown Pregnant at time of death 9 Unknown been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Ves 2 No director, page 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: ၉ 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 🗌 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10/27/2011 D35206

State

31. Date filed (Month, Day, Ye 28 2011

WILLIAM TANNER 11701 LIVINGSTON RD. 32. Registrar Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

#101 FT. WASHINGTON, MD

20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-08153 State of Maryland / Department of Health and Mental Hygiene Raymond Depaul Anderson Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2011 0847 hrs Medical Examiner Raymond Depaul Anderson c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street end number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In vrs. last birthdav) If Under 1 Year 5. Social Security Number **579–68–138**5 6. Sex **Funeral** Min Months Davs Hours Country) June 13, 1952 DC Director 1 M 2 F 59 ۷rs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10b County 1 Yes 2 No Hyattsville 23a or 28a-f show Maryland Prince George's death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20785 1619 Roosevelt Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. than "natural", or items Armed Forces? 1 Never Married 2 Married 1 Yes Specify: Black If Yes, Give Year Yes 2 X No specify: 4 Divorced 3 X Widowed hours after 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) nit. Pages 1 and 2 should be filed within 72 1 artment of Health and Mental Hygicine. portant: If item 27 is marked other than ", iry or other traumatic event, the Medical R. Baltimore, MD 21215-0036 Government Plaster 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Johnson Raymond Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20745 Oxon Hill, Maryland 1815 Fenwood Avenue Aisha Anderson - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Landover, Maryland 2011 Harmony Donation 5 Other Specify. 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service License 0 4001 Benning Road NE Washington, DC 20019 wan Approximate Interval Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Narcotic (Morphine, Methadone) Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and AMENDED 23a, 27, 28a-f, per me, 5 per fh, g921, 11/29 Physician/Medical -14-11 **■** UNPENDED s attending physician for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Day Year Month 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown á Completed 24b. Were autopsy findings available 24a. Was an ficate has been s page 2 should b prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 Other:

Nursing Home 5 Residence 6 Other: DOA this 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death unknown 1 Natural 1 Yes 2 X No Pending fd 10-31-11 fd 8:12 am Director: d in by the f 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State Martin Luther King Jr Hirhway & Roosevelt Ave Cheverly Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide in vehicle determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 1, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month, Day Year) 32. Registrar Signat State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:47 AM Er1e November 201¹ William Bodie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 130 West Thomson Drive Ceci1 E1kton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral Director** 1 🗓 M 2 🗆 F 066-18-7943 Yrs 86 March 13, 1925 New York Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code Funeral items 23a 130 West Thomson Drive 21921 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, vvas Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates.1943-45 ed other than "natural", or itelevent, the Medical Examiner Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Long distance truck driver Transportation 12 Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic even မ William Bodie Irene Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Jane D. Bodie/Wife 130 West Thomson Drive, Elkton, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Department of Important: If it any injury or o November 8. Elkton, Maryland Donation 5 Other (Specify) Gilpin Manor Memorial Park 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. Signature of Funeral Service Licensee 103 West Stockton St., Elkton, MD ismo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER WITH METS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis as the ed by the attending detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 L Unknown 9 Unknown Division of Vital Records, P.O. ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; a Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29d, Date signed (Month, Day, Year) MI D0062190 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUGUSTINE HERMAN HWY SUITEA, CHESAPEAKECITY, MD SHAHNAWAZ KHAN 33 31. Date filed (Month, Day, Year) 32. Registra 's Signature State NOV 1 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a per med cert G922 12/5/11 dk
State of Maryland / Department of Health and Mental Hygiene = State
Registrar Amend#10c&10eperfuneralhome10/25/2@entificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10/22/2011 Physician/ 0010 John Wilbur Barnes Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Cheverly Prince George's Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Social Security Number Funeral Days 79 Hours 14977774932 13**€34**M 2 □ F 220-30-2028 **Director** Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 √ Yes 2 🗆 No NC Cumberland Fayetteville Fayettville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5808 Lesiure Lane Funeral 28314 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Specify: 3 Widowed 4 X Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. Joseph Shepaly Barnes Mary Rozenia Edgerston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5808 Lesiure Ln. Fayetteville, NC 28314 Colleen Kay Petersen/dtr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/29/201 cemetery, crematory or other place)
Imm.Church Cemetery 1 Nurial 2 Cremation 3 Removal from State Lexington Park, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral 21. Signature of Funeral Service License 2294 Old Washington Rd Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Due to (or a consequence of): Medical resulting in death) **Examiner** Sacral decibitus--infected state I Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of Affected mental status that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the atte Vear Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End stage renal disease, hypothyroidism 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Hypotension, lower_gastrointestinal bleeding 24a. Was an autopsy this certificate has perform 1 ☐ Yes 2 ☐ No **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After work?
1 \(\sum \) Yes 2 \(\sum \) No iniury 1 Natural 5 Pending Accident Investigation within 24 hours after deatl To the Funeral Director. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) rillege Nevemb 20 Year, Registrar's Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 12:00 P M Delores W. Brown Oct. 20 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 5923 John Adams Drive Camp Springs, 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 79 425 48 8077 March 1932 Mississippi Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Maryland Camp Springs Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20748 5923 John Adams Drive 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify Completed 3 🛱 Widowed 4 🗆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Daisy Goff Arthur Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 English Oak Court, Waldorf, MD 20601 Judy A. Brown (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 12/8/2011 Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Sign re of Funeral Service License 100155 Ferry Road, CLinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 Yes

Ph_{sician/} Medical **Examiner**

Department of H Important: If ite any injury or otl

28a-f show

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Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Sant: fiten 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Exami

Baltimore, Maryland 21215-0036

Examiner

notified at

with the Maryland

attending physician and for use as the burial-transit I or Attending Physician: The law requires that the death certificate beafter death.

Director: After this certificate has been signed by the attending physicis signed by the at d be detached for Completed should peen page 2 this certificate completed filled in by the funeral director, Be ပ Certificate:

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **2** No Hospital: Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 \square Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pfactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, 22

20

29c. License number

Division of Vital Records, P.O. Box 68760

Registrar

within 24 hours a To the Funeral C Hospital 24 hours a

Medical

29a. Certifier

(Check only one) 29b. Signature and title o

Amir Alikhani, M.D. 101 Sentennial Street, #1890, LaPlata, MD 20646 31. Date filed (Month Ü

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

11-07777 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Steven Alan Belkov, Jr. State of Maryland / Department of Health and Mental Hygiene 36018 1. For State Certificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2020 hrs **Medical Examiner** Steven Alan Belkov, Jr. October 16, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center LaPlata Charles 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Director Months Days Hours 1 X M 2 F Yrs 219-13-3728 31 09/22/1980 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 13a or 28a-f show nr other traumatic event, the Medical Examiner must be notified at once. Charles Waldorf rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 Humbolt Court 20601 USA Ö 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married Armed Forces' Yes 3 Widowed If Yes, Give Yeer or Dates: 1 Yes 2 X No specify: Specify: White 4 Divorced ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical 12 Electrician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Steven Alan Belkov, Sr. Nicole Cathreen Kramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole C. Kramer Belkov/Mother 4301 Humbolt Court, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, vortant: If it crematory or other place) 1 Burial 2 Cremation 3 Removal from State ield-Echols | 10/19/2011 | Charles | 10/19/20 4 Donation 5 Other Specify Brinsfield-Echols 21. Signature of Funeral Service Licenses 30195 Three Notch Rd., PO BOX 128 MD M00817 23a. Part I. Ent., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Mulitple Injuries Immediate Cause (Final disease . ≛xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, and Attending Physician: The law requires that the death certificate be executed cal UNPENDED has been signed by the attending physician: 2 should be detached for use as the burial -AMENDED Physician/Medi 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Dther (Specify) 1 Yes 2 No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, 8 examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Oct 16, 2011 Pedestrian struck by motor vehicle 1 Natural 1935 hrs Pending 1 Yes 2 ✓ No hours after death. Funeral Director: tely filled in by the 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 ___ Suicide Could not be or Town, State) 301 S/B Near Talbot Street, LaPlata, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 To the Hos within 24 ho To the Fun Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E October 17, 2011 010 30. Name and address of person who completed cause of death (Item 23a)

OCME 2006

State

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

Carol Allan, MD

OCIME

Assistant Medical Examiner

Registrar's Signat

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 3:41 PM Physician/ 2011 Caroline Bodkin Vivian Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall 30175 Gershwin Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours 01/19/1928 Virginia **Director** 83 578-34-4079 Usual Residence of Decedent show 10d. Inside City Limits ige 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.

t. If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 X No Charlotte Hall MD St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20622 30175 Gershwin Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked or any injury or other traumatic ever Waverly Crowther Iris Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30175 Gershwin Road, Charlotte Hall, MD 20622 William Lowell Bodkin/Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Memorial Burial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2011 Waldorf, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A.
20.195 Three Notch Rd PO BX 128 Charlotte Hail,
MD 20622 Signature of Funeral Service Licensee M00817 30195 Three Notch Rd PO BX 128 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final nemical pnumonitis
Due to (or as a consequence of): Physician/ a Chemical disease or condition resulting in death) Medical **Examiner** BYRS MARIE CHARCOT TOOTH Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗙 No Month Day 1 ☐ Yes ∠ ↓
9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Cerebrovascular dyspinagia 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work 1 ☐ Yes 2 🛣 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Colleen D. 10/20/2011 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Property of person who complete Nicholson Holly wood Md. 20636

State Registrar DHMH 17 Rev 7/2009 23348

31. Date filed (Mo

Year)

4

BBlo

Street

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 24 2011 Priscilla M. Brown 6:50 p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Hours 1 -20 -1 924 Country) Director 215-24-0794 87 MA Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 423 Yawl Drive 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced white and Mental Hygiene.
is marked other than "natur aumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Priscil Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leon Macdonald Bernice Hunnewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Robert F. Brown-Husband 423 Yawl Drive Ocean City, MD 21842 Itimore, Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 10-26-11 Millsboro, DE State Crem. 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Serv 108 William Street Berlin. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition gear-Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of attending physician and for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 😿 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu ☐ Accident ☐ Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) October 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DH 5 William H. Robins, MD, 9715 Healthway Dr, Berlin, 21811 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3602 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Oct 23,2011 Physician/ 6:10pmNell Criswell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg Wilson Health Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 4, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Griffin. Sept 84 **Director** 255-38-0908 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Yes 2 No Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20877 United States 211 Russell Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Specialist IBM 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F Nell Barrow Edward Prince Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 N. Utah St., Arlington, VA 22207 Howard Donald Criswell III/Son item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State 10-27-2011 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signatura Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Priset and Death Immediate Cause (Final disease or condition Physician/ years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to forms a ponsequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Was an autopsy performed To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has Completed filled in by the funeral director, page 2 s hagete 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

04/15

201 RUSSELLAVENUE GAITHERS BURG MID

H. Raber T Birschback Wil.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIRSCHBACH

		1 - For State Registrar	State of M	aryland	l / Depa	artment of H	lealth and	d Mental Hy	giene Reg. No			
Physic /Medi									OCT. 21,		3. Time of Death 10:55A M	
Exami		4a. Facility Name (If not institution, give 6917 Groveton Drix	7e	Clinton			r Location of De		P	4c. County of Death Prince George's		
Funeral Director		5. Social Security Number 227-07-2178 6. Sex 1 Graph 1 Graph 2								9. Birthplace (State or Fore Country), Virginia		
Maryland a-f show	tor	10a. State 10b. County VA Fairfax		10c. City, Burk	Town or Lo	cation			-		10d. Inside City Limits 1 ☐ Yes 2 🖾 No	
th with the 23a or 28	al Director	10e. Street and Number 9121 Fox Lair Dri	.ve			10f. Zip Code 22015			10g. C	itizen of What C	ountry?	
ITIC Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland hal Hygiene. do other then "netural", or Items 23a or 28a-f show event, the Medical Exerciter must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	Education rade completed) College (1-4or 5+) Tyes, Give Year or Dates: 1				naker 18. Mother's Name (First, Middle, Maid Ocie Cockrill Bok			14. Race - American Indian, Black, White, etc. Specify: Caucasian 6b. Kind of Business/Industry At Home		
Daltimore, Maryland ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "netural", or any injury or other treumatic event, the Medical Exercal any injury or other treumatic event, the Medical Exercal Pages.	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 1.2				kind of work done DO NOT use retired						
other	To Be Co	17. Father's Name (First, Middle, Last) Harry Bobst								iden Surname)		
Darifficor , Mai yian parmit. Pages 1 and 2 should by Department of Health and Menta Important: If them 27 is marked any injury or other treumstic e DRCB.		19a. Informant's Name/Relationship (T		lage Di-	6917	Grovetor		Rural Route Numb	MD 2	20735		
Pages 1 Thent of H Tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,	Fairfax Me			emorial oct.		Date t. 25, 2011	Fai	Pairfax, Virginia		
Dermit Departiment Importantia		21. Signature of Funeral Service Licens	and (C 04	23 9	902 Brado	lock Ro			VA ¹ 22U3	eral Home	
Pnysician /Medical		23a. Pann. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each li a. Dement	ine. :ia		er the mode of dyin	ng, such as care	diac or respiratory a	arrest,		Interval Between Onset and Death Years	
Examiner	er	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
attending physician and for use as the burishtransi	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or killur) that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):							
Attending Physician: The law requires that the death certifica refail. refailt. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of de Month	elivery Day Year		
w requires that the de been signed by the s	ted by P	Part II. Other significant conditions co Renal Failure		out not result	ting in the u	nderlying cause giv	en in Part I.				to the cause of death? Probably	
JOVISION OF VILGI DECOLDS, I or Attending Physician: The law requirest after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed								ormed?	prior to death?	utopsy findings available completion of cause of	
Physician this certifi al director	To Be	I ☐ fes 21x1N0	Hospital:		R/Outpatier		er: 4 🗆 Nursin	Death (Check only	idence		ecity.Residence	
To the Hospital or Attending Physician: The lay within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No						28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,			
To the Hospital or A within 24 hours after To the Funerel Dire completely filled in by		4 ☐ Homicide determined 29a. Certifier 11☑ Certifying Phy	building, e	tc. (Specify)			me, date and pl	City or To	own, Sta	te)		
thin 24 h thin 24 h the Fur mpletely	Medical	(Check only one) 2 Medical Exemone) 29b. Signature and title of certifier	ner: On the basis of and manner st	of examination	on and/or in	vestigation, in my o	pinion, death o	occurred at the time	, date a	nd place, and du	e to the cause(s)	
10		Michael	J 2	en	ta ur	D2143				26, 2		
		30. Name and address of person who a Michael J. LaPenta	a, MD	445	Defer	nse Highw	ay, Anr	napolis,	MD 2	21401		
St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 9.7 2011	32. Registr	rar's Signatu	bar	W.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36023 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 50 PM Alton Eugene
4a. Facility Name (if not institution, give street and number) Chapman Medical October 18 **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hopkins Hospita n yrs. last birthday) Funeral If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Country **Director** 1 🛛 M 2 🗆 F Marzylanc iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 6302 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1466 Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No 3 Widowed 4 Divorced Specify 1968 Black Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, <u>the Medical</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son hadman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

5+. Revers Cem 20c. Location - City or Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-MALCO Signature of Funeral Service Licensee Name and Address of Facility MD 20602 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) PEPSIS Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the a detached 1 Yes 2 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? Yes 2 X No 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 2 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 Pending injury s after death. Accident Investigation M 1 ☐ Yes 2 ☐ No. 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier RES-000 October 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bishow 600 N. Wolfe St Baltimore Maryland 21287 Ch Shrestha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death oďtober ™9 2041 16:06 Frederick Calvin Douglas, Jr. Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday, . Social Security Number Funeral Days Hours Director 223 50 6959 1 XM 2 | F 4/10/1939 DC "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location Director Waldorf 1X Yes 2 No Charles MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20603 2901 Hunt Court death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 0. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Photographer Manager Pentagon Be n and Mental Hyg 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gladys Harris Frederick Douglas, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Hunt Court Waldorf, MD 20603 item 27 Phyllis B. Douglas/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State 10/29/2011 Waldorf, MD Trinity Mem.Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Priscoe-Tonic Funeral Home 21. Signature of Funeral Service Licensee 2294 Old Washington Rd.Waldorf, MD 20601 teken Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner amenos cliso ra Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Yea Day Pregnant at time of death 5 Other (specify) 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy performed' 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 🗆 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Uniform Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely only one) 29b. Signature and title of certifie nn 10055120 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern avenu St Sute 310 BB6 l'almin and 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25 OCI Knuna Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36025 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ October 2011 7:30 A Mary Alveta Dade Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Ft. Washington 9100 Branchview Drive 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🗴 F Months Days Hours Min. Dec. 5 Day, Marviand 1926 84 Director 215-26-0675 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1X Yes 2 □ No Maryland | Prince Georges Ft. Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20744 9100 Branchview Drive items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Examiner Black, White, etc 9 ģ 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify "natural", 3 X Widowed 4 □ Divorced Completed th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Andrews Air Elementary/Seconday (0-12) College (1-4 or 5+) Custodian 8th. Force Rase Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ollie Proctor George Walter Swann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any Injury or other trauonce. 20744 <u>9100 Branchview Dr. Ft. Washington, MD.</u> Shirley Dade/ Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter's Cemetery Oct. 26, 2011 Waldorf, MD. Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home 20601 1400544 3035 Old Washington Rd. Waldorf, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ DEMENSIR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CS 000 Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir Y r attending physician and for use as the burial-transit 7 4 Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv performed? 1 Yes 2 No Yes 2 No. No. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Pay Year) 32 Registrar's Signature مسائلاسان

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6322 E 4702

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CRND

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LBGEB-e=

20646

LAPLATA, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Ameno#20c. PerFHPC10-28-11cr 36026 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month | D Day 22 Physician/ 20:277 VPIV izon Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number Examiner linton cince If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) -42-680 68 Director 01-11-1943 Usual Residence of Decedent 10d. Inside City Limits 28a-f show filed within 72 hours after death with the Maryland at 10a State 10b. County 10c. City, Town or Location Director ms 23a or 28a-f s must be notified 1 XYes 2 □ No itland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6016 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 9 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Asian "natural", 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉)IZON ourdes 2) Dionisio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores MD 20a. Method of Disposition
1

Burjal 2 A Cremation 3

Removal from State 20c. Location - City or Town, State Beltsville, 20b. Place of Disposition (Name of Date 10/26/2011 on 5 Other (Spe 4 Donat FUNERAL SERVICES 21. Sign CAMPSPRINGS, MD 20748 an 1. Enter the disease, or complications that caused the death. Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed trar that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months Month Day Year Pregnant at time of death 1 Yes 2 E the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 4 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After this completely filled in by the funeral di 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide Natural 5 Pending 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 24 (Check rtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License numbe 29d. Data signed (Month, Day, Year) 29b. Signature 30. Name and address of person who ted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36027 State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ochober 25° 201^Y 6:45А. м Physician/ Eggleston Louise Marjorie Medical 4c. County of Death Montgomery 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death **Examiner** 10225 Frederick Avenue, #612 Kensington 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Days Hours Sept. 16, 1923 New York 1 □ M 2 🗓 F 88 118-16-6375 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Maryland Montgomery Kensington 1 XYes 2 No 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 20895 Funeral 10225 Frederick Avenue, #612 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, White þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.

27 is marked other than 'traumatic event, the Me College (1,4 or 5+) Elementary/Seconday (0-12) own home Homemaker 8. Mother's Name *(First, Middle, Maiden Surname)* Julia Maxwell 17. Father's Name (First, Middle, Last) ٥ Paul Crandall permit. Page 1 and 2 should be Department of Health and Meni Important: If Item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10225 Frederick Ave.,#612 Kensington, Maryland 20895 19a. Informant's Name/Relationship (Type, Print) Brian Eggleston -son 20a. Method of Disposition
1 □ Burial 2 🌣 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date matory or other place) Metropolitan Crematory 10/25/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune 11 ervice License, Bonalad ViesBorgwardt Funeral Home, PA Maryland 20705 (W) 4400 Powder Mill Road Beltsville, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or iterat failure. List only one cause on each line. Approximate Interval Between 2 years Immediate Cause (Final disease or condition Ph sician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examiner Ischemic Heart Disease Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 XNo 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: Other: 2 XNo 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural work' 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 2 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D52385 October 25, 2011

State

Registrar

Kristin E. Thomas, M.D. 3301 New Mexico Avenue, N.W., #342 Washington, DC 20016

WILLEST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 2 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ JUNIUS ROBERT ELLIOTT, SR 5:30 OCT Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY BETHESDA 8. Date of Birth
(Month, Day, Year)
6. 1930 WRNMMC '. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** Min. Months Hours 1 🔀 M 2 🗆 F 81 Virginia Director 230-26-9635 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **Funeral Director** must be notified ty∑ Yes 2 ☐ No Silver Spring Montgomery Co. Md. 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Numbe 23a U.S.A. 20910 9102 2nd Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. ed Forces 2 1 Never Married 2 Married 1 X Yes 2 If Yes, Give þ If Yes, Give 1952–1973 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Army Administrative 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည McGhee Keziah Elliott Robert Berkley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1703 East-West Hwy., #715 Silver Spring, Md. 20910 Daniel Elliott - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Arlington Nat'l Cem. 11-29-2011 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home Signature of Funeral Service Licensee 10583 Middleport Lane, White Plains, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition INTERSTITIAL LUNG DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 ☐ Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one

State Registrar

DC

29b. Signature and xi0e of certif

MARYANN

31. Date filed (Month

30. Name and address of person who

ALLY

arked

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

0101245449 (VA)

10

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36029 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ Month NOVEMBER BETTY LUCILLE FRENCH 12:30P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 X F April 12, Year 1927 219-20-4751 84 Maryland **Director** Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Director Examiner must be notified Maryland Frederick Brunswick 1 K Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9 East C Street 21716 United States of America within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc 9 δ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural" 3 XWidowed 4 Divorced Specify: Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be filed Department of Health and Mental H Important: If item 27 is marked out any injury or other *** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Smith Ruth Souders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl J. French, Jr. 222 Third Avenue, Brunswick, Maryland 21716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State November 9. 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Mount Olivet Cemetery Frederick, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Keeney & Bastord P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ potension disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed hours after death. Ineral Director: After this certificate I 1 Yes 2 No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner? Hospital Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 \square No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Egrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30 5:05 Рм Denis Frank Forsting Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 1 X M 2 D F Hours (Month, Pay, Year) 68 **Director** 312-46-3494 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Maryland Frederick Mount Airy 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be 13260 Penn Shop Road 21771 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give White Completed 3 Widowed 4 Divorced Specify: Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Factory Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Clem Forsting Estella Thiel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mariya Forsting / Wife 13260 Penn Shop Road, Mount Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 4. injury (St. Louis Cemetery 2011 Batesville, Indiana any in 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home, 106 East Church Street, Frederick, MD 21701 MO1473 23a. Pm. 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw theum omia Immediate Cause (Final Odays Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Immunofulpresion Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Chronic Lymphocytic Lentomia Cause (Disease or linjury that initiated events resulting in death) Last attending physician Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal cell carcinoma Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Acute or Chronic Reval Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Septic performed Shock 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ည 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending **⊠**Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 🗀 Yes Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 W 7th St Frederick mo 21701 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Registrar

11-08175 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Thomas Fuller, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day October 31, 2011 **Medical Examiner** 1710 hrs William Thomas FULLER, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital Oakland Garrett 5. Social Security Number If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Director Hours 1 X M 2 F Country)Maryland 214-58-8432 Yrs Dec. 19 1952 58 Usual Residence of Decedent i 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Y Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mortell Hygien.

Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be nofified at once Maryland Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 838 Monet Drive 21740 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White 2 or Dates:

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 2 Construction Construction Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Thomas Fuller, Jean E. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Fuller - Son 838 Monet Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Hagerstown Crematory 11/3/2011 | Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service License 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and .Medical aHypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, pt. II, 27, per me, g921 11-18-11 sm X UNPENDED e attending physician for use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. his certificate has been signed by director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? 2 Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy this certificate has performed? ✓ Yes 2 No death? 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other, Nursing Home 5 Residence 6 Other 1 Yes funeral After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending within 24 hours after death. 1 Yes 2 No To the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 [(Check only one) 2 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 1/2001

Medical

Drassel 30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Melissa Brassell, MD

0

and manner stated

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 1, 2011

To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital

| X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Oct.21,2011 D39793

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2:40p M

g. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 Yes 2 No

Year

Month

1 🗆 Yes 2 🎽 No

Country)

White

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Mays MD 18111 Prince Philip Dr.#207 Olney, Md 20832

State Registrar 82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36034 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 2011 Pauline Emily Gordon OCTOBER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death -WISTA MEDICAL PLATA CHARLES CENTER If Under 1 Year Social Security Number 6. Sex 1 ☐ M 2 🔀 F If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthplace, Country) NH Days Months Hours Min. May 30, 1929 005-28-5164 Director 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Charles Welcome 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 9065 Gunston Rd. 20693 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married land 21215-0036 Specify: White 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DONOT use retired)
Educator 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Roberge Emily Gilliland Roberge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20693 Clifford M. Gordon/ Husband 9065 Gunston Rd. Welcome, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Brinsfield Echols Crem. 10/25/11 Charlotte Hall, Md. 4 Donation 5 Other (Specify) 21. Sig sture of Funeral Service Licenses 22. Name and Address of Facility MOO945 AREHART-ECHOLS FUNERAL HOME, PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20646 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DVANCED NUSCLEARD YES Physician/ disease or condition rens Medical resulting in death) Due to (or as a consequence of): **Examiner** EMENTIN STACK IV 2HEIMEN S Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Day Pregnant at time of death io tne Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached i Part II. **Other** s<mark>ignificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 🗌 Yes Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending 2 🗆 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying, Nurse Practioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEOR 1134 USHTAW PEMBROOKE SQUARE, SUITE 31. Date filed (Month, De 32. Registrar's Signature WALPORF, MD State 0 Registrar

JORDON, PAULIN

lease Type or Print in Black Indelible Ink. Ensure All Copies Are டிளிம்.	36035
State of Maryland / Department of Health and Mental Hygiene	
cperfuneralhome10/26/2011cc Gantificate of Death Reg. No.	

			1 - State of Maryland / State of Maryland / State Registrar Amend#4cperfuneralhome10/26/2011c	Department of Health and Mo	, ,				
	Physicia		Decedent's Name (First, Middle, Last) Hisako Jeannie Gilliland		2. Date of Death October 19	3. Time of Death			
	Medi Examii		4a. Facility Name (if not institution, give street and number) 7685 Kent Drive	4b. City, Town, or Location of Death Charlotte Hall	40	C. County of Death St. Mary's Charles			
	Funeral Director		5. Social Security Number 555-62-1287 Usual Residence of Decedent 6. Sex 1	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 02/02/1932	9. Birthplace (State or Foreigr Country) Japan			
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town	n or Location otte Hall 10f. Zip Code	100.0	10d. Inside City Limits 1 ☐ Yes 2 😿 No			
	with the same same same same same same same sam	eral	7685 Kent Drive	20622	(1)	SA			
9036	urs after death ural", or items il Examiner m	Completed by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 1 Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian			
15-(72 hou n "nat Aedica	nple	(Specify only highest grade completed)	. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	g 16b. k	Kind of Business Industry			
212	within giene. er tha	ပ္ပြ	Elementary/Seconday (0-12) College (1-4 or 5+)	Chef/Schools	Fo	od Service			
Maryland 21215-0036	uld be filed Mental Hy narked oth natic event	To Be	17. Father's Name (First, Middle, Last) Eikichi Shibasaki		18. Mother's Name (First, Middle, Maiden Surname) Namie Kobayasai				
Mar	2 shouth and the and the street the street traum			o. Mailing Address (Street and Number or Rural F 622 Leonardtown Road					
	ge 1 and it of Heal if item ?		20a. Method of Disposition 20b. Place of	f Disposition (Name of Da		MD 20601 ocation - City or Town, State			
Baltimore,	Page ment o tant: If tant: If jury or			ry, crematory or other place) ield-EcholsCrem。10/21	/2011 Cha	rlotte Hall, MD			
Ball	permit. Page 1 Department of Important: If is any injury or c		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Brin 30195 Three Notch Ro					
	Physician/ Medical		23a. Part 1. Exter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence or consequence o	not enter the mode of dying, such as cardiac or a	respiratory arrest,	Approximate Interval Between Onset and Death			
09	Examiner	_	ıysician/Medical Examiner	nysician/Medical Examiner	edical Examiner		LAROTTE CARDIOVASCULAR	C DISKASK	3 YRS
. Box 687	tth certific ttending p or use as				IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
s, P.O.	res that the dec signed by the a I be detached f	d by Pl	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		use contribute to the cause of death?			
of Vital Records,	sician: The law require s certificate has been si lirector, page 2 should	Completed			24a. Was an autopsy performed?	No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No			
/ital	sician s certifi lirector	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Check o					
on of \	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) in	Itpatient 3 L DOA 4 L Nursing Home	ne 5 Residence 6 3d. Describe how injur				
Division	vital or Attural or attural or after de ral Directo	al Certi	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)		City or Town, State				
	the Hosp hin 24 hor the Fune npleted fi	Med	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, conly one) 1 Certifying Physician: To the best of my knowledge, conly one) 2 Medical Examiner: On the basis of examination and/or only one)	r investigation, in my opinion, death occurred at th	ne time, date and place	e, and due to the cause(s) and manner state			
0	To with		29b. Signature and title of certifier Mbut 1 Bauer mo	29c. License number D0014168		tte signed (Month, Day, Year)			
	388		30. Name and address of person who completed cause of death (Item 23a) (1 2 F 103 Mtree Not Ch Nd SUITK	Type, Print) 101 MECHANICS VI	le, md z	0659			

State Registrar

31. Date filed (Month, Day, Year)
OCT 24 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 36036 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1, 201^{Year} November С. 10:15 AM Mary Hendrickson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death E1kton Ceci1 Abbey Manor Assisted Living Facilit Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Director 215-32-3353 1 M 2 X F Nov. 16, 1921 Maryland and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-1 sirce.

I warked other than Medical Examiner must be notified at or 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director E1kton 1 Yes 2 X No Marvland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1797 Old Elk Neck Road 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laboratory Technician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Childress Sarah Keen and 2 should be Health and Meren 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luna Racine/Daughter 1797 Old Elk Neck Road, Elkton, MD permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 4. 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Hopewell Cemetery Port Deposit, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility
103 W. Stockton St., Elkton, MD 21921 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cau e on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): buriat-Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 3 🗍 Probably 🛂 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? or Attending Physician; The 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specific မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

Records,

Division of Vital

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completed cause of death (Ite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36037 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Grace V. Grover Hill Nov. 20T1 1:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs
Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 214-36-4758 1 🗆 M 2 💢 F 73 Jan. 23, 1938 Maryland Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits irector 1 🔀 Yes 2 🗌 No Baltimore MD White Hall ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1920 Hunter Mill Road 21161 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 0 1 X Never Married 2 ☐ Married à Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: White 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Franklin Grover Ruth N. Canon-Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1920 Hunter Mill Rd., White Hall, MD 21161 Fedellia B. Hopkins / Daughter Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State West Length Cemetery United Nov. 2011 Page 1 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) White Hall, MD 21161 Methodist Cemetery 21. Signature of Tuneral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. any 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ chronic obstrictive pulnonin disease or condition 1 cars Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 30 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the Within 2 only one 29b. Signature and title of certifie November 4 Zevi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES 6701 MD NOINST

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year) NOV 1 0 2011

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar Signature

Registrar

DHMH 17 Rev 7/2009

2. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 20<u>11</u> Physician/ Oct. 5:15 AM Knight Holland 21. Edna Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Calvert Nursing Home Prince Frederick Social Security Number r 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2XX Days Hours Jan.28, 1931Richmond, VA 80 228-34-3237 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Prince George's Morningside Marvland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 20746 U.S.A. 6605 Randolph Road death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Flementary/Seconday (0-12) College (1-4 or 5+) Home owner Homemaker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bruce Leslie Sapp Knight Dorothy Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5008 Roanoke Place, College Park, MD Carolyn Bennett- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery Oct. 28, 2011 Suitland, MD 22. Name and Address of Facility Lee Funeral Home, Inc. M0155 21. Signature of Funeral Service Licer 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 1 Yes 1 ☐ Yes 2 ☐ ★o Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 잍 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No М Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certi 29d. Date signed Month, Day, Year) 1006 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lo DC Manoj Mathur 110 Hospital Rd. Suite 305 Prince Frederick, MD 20678

DHMH 17 Rev 7/2009

Registrar

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10/18/2011 SYMONE CHARELL JOHNSON 0618 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University Specialty Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** Age (In yrs. last birthday) 8. Date of Birth MD Country) 9. Birthplace (State or Foreign 1 □ M 2X F Months 01/22/1992 **Director** 214-35-6556 19 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Anne Arundel 1 X Yes 2 No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3576 Spring Road 20724 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🏻 No Specify. 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Student Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ivory Smith Jacqueline Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Smith/mother 3576 Spring Road, Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 2 Cremation 3 Removal from Stat n 5 Other (Specify) Μt Zion UMC Cem. 10/26/2011 Laurel, MD uneral Service Licens 21. Signature of 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Pulmonar Lypertension disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Obstructive sleep apnea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the attending the control of the standard of that initiated events resulting in death) Last Due to (or as a consequence of): the buris Physician/Medical inding physicla use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u Live Birth Z L Feta Con Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Dav g Unknown g 🔀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page perform 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပ 1 X Inpatient 2 -ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 2 Accider
3 Suicide Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ⊅54339 the 10-26-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HSHRAF 130013 MD 601 South Charles St.; Baltimore, MD

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36041 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 2 Physician/ 2011 5:15 AM Jones Robert Earsom Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Devlin Manor Nursing Home Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Hours Apr 3. 1943 Director 214-42-2366 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director Cumberland Allegany MD 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò Funeral items 23a USA 21502 21 Blackiston Avenue 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ō þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: "natural", Completed 3 Widowed 4 Divorced white Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service 12 Custodian and Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked or any injury or other traumatic eve ည Elma Earsom Robert L. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10411 Witt Lane SW LaVale MD 21502 10411 Witt Lane SW Larry Anderson friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cemation 3 Removal from State 11/3/2011 Scarpelli Funeral Home, P.A. MD Cresaptown ☐ Donation 5 ☐ Othen(Specify) ignature f Funeral Servi 22. Name and Address of Facility Scarpelli Funeral Home, PA Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 0 ulen Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant Pregnant at time of death 1 | Yes 2 L 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 TUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of 29c. License number 2011 0067565 5gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JBALLINO 922 Net MO 11504 TD

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 1 0

Darks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per me, g921, 1171872011dfb 36042 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Artur Gennadievich Karpov 525 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Medical Allegany Cumberland 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 216-61-5781 Russia 48 Director 1 XM 2 | F ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h Coun 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Gaithersburg 1 Yes 2 No 10e. Street and Number 10a. Citizen of What Country? Funeral 161 Sharpstead Lane 20878 Russia Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 Married by 2 XNo Baltimore, Maryland 21215-0036 72 hours after 1 Yes If Yes, Give White 1 ☐ Yes 2 M No Specify: and Mental Hygiene. 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b, Kind of Business/Industry (Specify only highest grade completed) Sewelloper Software Elementary/Secondary (0-12) Radius Travel College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Glennady Karpov Valentina Marchenkova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant; If item 27 is Olga Karpova/Wife 161 Sharpstead Lane Gaithersburg, Md 20878 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1. Department of Important: If ite cemetery, crematory or other place) 9 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 10/29/2011 4 Donation 5 Other (Specify) Beltsville, Md injury (21. Signatur PHYLPIPADERINALDI FUNERAL SERVICE, P.A. any Aru 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) an and CAL EXAMINER that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the buria attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ò Month Day Year Pregnant at time of death Unknown signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires Completed 1 Yes 2 No 3 Probably should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform death? certificate 2 🗌 No Yes Vital or Attending Physician: director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital Other: 1 X Yes Impatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral o 27. Manner of Deth Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No Division Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ompletely filled in by Homicide determined City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 10 Lysician 23 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vun Desver 12500 La 1/1 ombr. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 7 OCT Registrar

11-08002 James Kabomg

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		21202 Sparrow Court	. number)	Germanto							
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Pages lent of		4 Donation 5 Other Specify:	i nom otato	ls' Cemet	ery 10/	29/2011	Germantow	n, MD			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f aho injury or other fraumfic event, the Medical Examiner must be notified as anone		21. Signature of Funeral Service Licenspe	229	Name and Addre	ss of Facility Mortuary	Servic	e. p.a.				
		23a. Part I. Enter the disease, or complications that	MUU936 7	/ Park Av	enue, Gai	.thersbu:	rg, MD 208.				
Physiciar /M		failure. List only one cause on each line.	it caused the death. Do not ente	er the mode of dying	g, such as cardiac d	r respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death			
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Division of Vital Records, P.O tat or Attending Physician: The law requires that t is after death. and Director: After this certificate has been signed by led in by the funeral director, should be detacted.	Pe						2 No 3 Pro				
Ords, aw requir as been s	Completed					24a. Was a autops	y prior to	utopsy findings available completion of cause of			
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Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical examiner? [Hospital: 4]	1		ce of Death (Check						
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Vision or Attene or Attene of Attene	<u>;</u>	2 Accident Investigation Oct 2	4, 2011 1546 hrs lace of Injury - At home, farm, st			28f. Location (S	reet and Number or Ru	ural Route Number, City			
italor Is after led in Dick	Certification:	Suicide Could not be	fy) Hanging from deck		•	or Town, St					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The That the remaind present the certificate has been signed by the attending physician and the Phones after the remaind director, page 2 should be detached for use as the burst.	a C	29a. Certifier 1 Certifying Physician: To the I	pest of my knowledge, death occ	curred at the time,	date and place, and	due to the cause	(s) and manner as stat	ed.			
Division To the Hospital or Attend within 24 hours after death. To the Fuoeral Director: completely filled in by the 8	Medical	one) 2 Medical Examiner: On the bas and manner	is of examination and/or investiger stated.	gation, in my opinio	on, death occurred a	at the time, date a	nd place, and due to th	ne cause(s)			
2	Ž	29b. Signature and title of certifier	\wedge		nse number		29d. Date signed (Mo				
		Carol Hal	yan	0.0	.M.E.		October 25, 201	7			
		30. Name and address of person who completed c	ause of death (Item 23a) al Examiner 900 W. B	altimore Stree	t Baltimoro M	D 21223					
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Regi	State	1 DOT 017 2011 LA	Registrar's Signature	1600							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Edwin Leavitt October 22, 2011 5:45A. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's **Examiner** City, Town, or Location of Death Renaissance Gardens at Riderwood Village Silver Spring 7. Age (In yrs. last birthday) 90 vrs If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Nebraska **Funeral** 8. Date of Birth Days Sept. 21, 1921 507-14-0666 1 💢 M 2 🗆 F Hours Director Usual Residence of Decedent show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 🕅 No Maryland Prince George's Silver Spring 10e. Street and Number 10f. Zip Code and Mental Hygiene. Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r 10g. Citizen of What Country? Funeral 3156 Gracefield Road, OP503 20904 United States within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Satellite Comunications Electronic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev George Arthur Leavitt Sarah Jane Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Fraser Leavitt -son 2206 Larchmont Drive Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 11/1/2011 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, Maryland Funer & Service License Donald dovode Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Athorosologous (Cardiovascullar, Discosso Approximate
Interval Between
Onset and Death
Year Ph sician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cerebrovascular Accident 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and and Congestive Heart Failure Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events 4 years Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Chronic Obstructive Pulmonary Disease 5 years Division of Vital Records, P.O. Box 68760 nding _k se as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Pregnant at time of death 2 No. Unknown 9 Unknown signed by tl d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? autopsy 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A leted filled in by the ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2. 3 Secrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, 112633 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julaine Harding, NP 3160 Gracefield Road Silver Spring, Maryland 20904 31. Date filed State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36045 State of Maryland / Department of Health and Mental Hygiene 2 [] For State Certificate of Death Time of Death 818 AM _M Decedent's Name (First, Middle, Last) 2 Date of Death Ownober 20, 2014 Physician/ Markey Linda Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** Days Min 1 □ M 2 🗓 F Cleveland, OH Director 289-32-7660 or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or Funeral 5102 Cape Cod Court United States 20816 14. Race - American Indian, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education French Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Rothaus Leo Markey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5102 Cape Cod Court Bethesda MD 20816 Jeffrey S. Berlin - Husband Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 10/24/2011 Falls Church, VA National Crematory 22 Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 . Signature of Funeral Service La M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Clostridium Difficile Colitis Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death the detached 9 Unknown o signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, Acute Renal Failure, Respiratory Failure 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) October 21, 2011 D0060117 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Park MD 8600 Old Georgetown Road Bethesda MD 20814 31. Date filed (Month, Day, 32. Registrar's Sign State Registrar

1:80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct 23.2011 Mitchell Buzanne, 5. 9:20 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 111 Carlson Lane Queen Anne's Stevensville 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Hours Min. (Month Country) Virginia Director 225-40-8117 1933 Nov Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Queen Anne's Stevensville 1X Yes 2 ☐ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 111 Carlson Lane 21666 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Education School Teacher permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George B. Sublett Edith Murvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward F. Mitchell/Husband 111 Carlson Lane, Stevensville, MD 21666 20a. Method of Disposition
1

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10-26-2011 Alexandria, VA 21. Signature Aneral Service Lice 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part Immediate Cause (Final Onset and Death Physician/ Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner insufficier Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed atheroso and cosonory Due to (or as a consequence of) nding physician use as the burial Physician/Medical P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atter in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \) \(\text{No} \) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 this certificate 1 Yes 2 No Yes 2 XN **Division of Vital** director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2.2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending work?
1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: At Completed filled in by the full death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar Day,

3 🗆

only one) 29b. Signature and title of certifie

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sullivar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0072375

29d. Date signed (Month, Day, Year) 10, 24, 2011

Annapolis, MD 21401

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0 3. Tibee of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 13 OCTOBER 9:02 P M G. MITCHELL 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF THE CHESAPEAKE DISTRICT HEIGHTS PRINCE GEORGES 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min MA(Yont 30 ay, 1 9 1 8 CASWELL 238-24-5285 93 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD PRINCE GEORGES MT. RAINIER 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3220 CHILLUM RD. APT.#202 20712 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates BLACK 1 ☐ Yes 2 X No Specify: Specify: should be filed within removed. It and Mental Hygiene.

27 is marked other than "natural" "natural", 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECURITY PRIVATE 8TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ WINSTEAD permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is markel any injury or other traumatic once. PENNIX FANNIE MURPHY traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LONGZITTA MITCHELL/GRANDDAUGHTER 1200 NORTH CAPITAL ST. NW. APT#C-810. WDC. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM. 10/24/2011 | SUITLAND, MARYLAND 21. Signatu e f Fungial Service Licenses 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 716 KENNEDY ST. NW, WASHINGTON, DC 23a: Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ATHEROSCLEROTIC HEART DISEASE Medical Due to (or as a consequence of) Examiner CONGESTIVE HEART FAILURE Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed HYPERTENSION and I-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical CHRONIC OBSTRUCTIVE PULMONARY DISEASE Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Dav Pregnant at time of death the 8 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available 24a. Was an nas e 2 autopsy performed? Yes 2 X No prior to completion of cause of death? page certificate 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗓 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined h.
in 24 hou.
o the Funeral D'
completed fille Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Ortifying Nurse Practione To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 16523 10/24/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDRE MICHALAK, 1140 VARNUM ST. NE #205B, WASHINGTON, DC 20017 31. Date filed (Month, Day, Year 32. Registrar's Signature State OCT 2 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36048 State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ODESSA MASON 2:00p M 2011 T Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OLNEY MONTGOMERY MENTGONIERY GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 92 578-16-4170 Director 1 □ M 2 🏝 F 8 12 1919 VA 10a. State with the Maryland aţ 10b. County 10c, City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 5232 First Street NW 20011 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 ₩ Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Self Employed Self Employed traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i and Mental ဂ္ဂ Alan Harrison Clara Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Donna M. Mitchell / Daughter 2317 Kaywood Lane Silver Spring MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5 Other (Specify 4 Donation art Lincoln 11-1-2011 Brentwood, MD permit. 21. Signature of Emeral 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ MASSIVE INTRACRANIAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** LUNG Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed use as the burial-tran and Due to (or as a consequence of): nding physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ģ Pregnant at time of death Month Day Year signed by the a ld be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, CANCER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

The Funeral Director, After this certificate has b completely filled in by the funeral director, page 2 s autopsy performe 2 No 2 N 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural $5 \square$ Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) FOEWENME, MED D59418 OCTOBER 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CR ADEWUNMI, MA. MONTGOMERY GENERAL HOSPITAL LUYEMISI 31. Date filed (Month, Day, Year, 32. Registrar's Signature State OCT 2 8 2011

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar ma Certificate of Death ESV Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Morris F. Oxman Medical 1100 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death Montgomen thei **Funeral** Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Country) PA 1 🔀 M 2 🗆 F Hours Min. Sep. 3, Year 910 220-46-1277 101 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Montgomery 1 X Yes 2 No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 Old Georgetown Road, #2415 20814 USA 12. Was Decedent Ever in 195, 4 Armed Forces? 1 4 Yes 2 No 1946 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 Yes 2 No Specify: White "natural", Completed 3 Widowed 4 X Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ıl Hygiene. I **other than** " Elementary/Seconday (0-12) College (1-4 or 5+) Psychoanalyst it. Page 1 and 2 should be filed with thrent of Health and Mental Hygier trant: If item 27 is marked other 1 njury or other traumatic event, the Psychology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Aron Oxman Rosie Valinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael L. Oxman, Son 36963 Charlestown Pike, Hillsboro, Virginia 20132 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Crematory Date 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🔀 Removal from State 10/26/2011 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Addres Chapels Mcgreenhos 170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) abdominal Dortic Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed Cerebra that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No Yes 24 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica eqompleted filled in by the funeral director, p. Division of Vital Be 25. Was case referred to predical , MORR 26. Place of Death (Check only one) examiner? ဂ္ 1 🗌 Yes . 2 📝 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Accident Investigation 2 🗆 No Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 1026 and address of person who completed caus e of death (Item 23a) (Type, Print) Anitha Pesala Chetty 8600 Old Georgetown Road, Bethesda, Maryland 20814 MD 31. Date filed (North Day Year State Registrar

1100186

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 36050 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Ohemaa-Afia Sarpomaa Opoku October 24, 2011 10:45A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** OCCC+, 21, 72011 1 M 2 XF Hours none Marvland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Howard Laurel 1 Tes 2 No 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? rral", or items 23a or Examiner must be r Funeral 9802 Whiskey Run 20723 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces 2 Black, White, etc. 1 Never Married 2 Married þ hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specif African American "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the none none Be 18. Mother's Name (*First, Middl*e, *Maiden Surname)* Lydia Duah 17. Father's Name (First, Middle, Last) Ith and Mental H
27 is marked of
traumatic ever Charles Opoku permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Opoku -father 9802 Whiskey Run Laurel, Maryland 20723 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cate of Heaven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/2011 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonard Vie Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Trisomy 13 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Doe to for as a consectionds of: or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant a
9 Unknown for in the past 12 months? Month Day Year Pregnant at time of death detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? this certificate 2 1 No Yes 25. Was case referred to medical å 26. Place of Death (Check only one) examiner Hospital Other: 1 Yes 2 No Certificate: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 5 Pending 2 \square No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

s after death. I Director; After th filled in by the I within 24 hours a To the Hospital сопретен

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 25, 2011 D55515

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrea Lotze, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

State Registrar

Medical

29a. Certifier

(Check

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene ? 36051 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dctober 2011 0:40 A Theresa Parr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charles 1111 Cornell Lane Waldorf f Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Hours Min Months 88 **Director** Yrs 1923|Maššačhusetts 036-12-9773 March Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director XX Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1111 Cornell Lane 20602 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White If Yes, Give Year or Dates Specify 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "no any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Dwn Home 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Patrick Hanlev Alphonsine McGee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Breads/ Granddaughter <u> 14180 Meadow Creek Ln. Waldorf. Marvland 20601</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. Date , 2011 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Unknown** Arlington, Virginia Arlington_National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home BO35 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ 6 disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No after death М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe signed (Month, Day, Year, person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 2 DC 31. Date filed (Month Day, Year, 32 Registrar's Signature State 2 6 arks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36052 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23 2011 PATTERSON MARY Ι. OCTOBER 12:59 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 226-03-6247 Director 1 🗆 M 2 🗓 F 97 Yrs FEBRUARY 2,1914 VIRGINIA Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1X Yes 2 ☐ No MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code õ 10g. Citizen of What Country? Funeral 23a 901 ARCOLA AVE. 20902 USA er than "natural", or items the Medical Examiner mu within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Was Deces? Armed Forces? → Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: AFRICAN-AMERICAN If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 7TH DOMESTIC PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည **JOHNSON** permit, Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. other traumatic .IOHN SARAH J. CHILDRESS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY STEWART/DAUGHTER 1034 CREST HAVEN DR., SILVER SPRING, MD 20903 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State GLENWOOD CEMETERY WASHINGTON, DC 10/27/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re Funeral Service Lice 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME , NW, WASHINGTON, DC 20011 716 KENNEDY ST. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PNEUMONIA Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗶 No Day Month Year 5 Other (specify) Pregnant at time of death g Unknown g Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XNo မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) After t Certificate: 28b, Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No after death.

Director: A
d in by the fu М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

complet Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, D56691 OCTOBER 23, 2011 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 12107 HERITAGE PARK CIRCLE, SILVER SPRING, MD 20906 GHOUSIA SULTANA,

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month Day) say

32. Registre's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October Bernard Rouse 2011 10:15AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Clinton Southern Maryland Hospital George's Prince If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Days Hours 547-92-6753 Director 1**X** M 2 □ F 59 0/24/1952 NC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Prince George's MD Temple Hills 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 4107 Holly Tree Road 20748 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 \overline{\text{Y}} \text{Yes} \ 2 \overline{\text{No}} \ No \text{If Yes, Give} \ Year or Dates. \frac{1}{2} 972-76 Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify.Black "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Private 4th Computer Programer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William H. Rouse Oueenie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 4107 Holly Tree Rd. Temple Hills, MD 20748 Cheryl M. Christmas/Friend 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem. 11/4/2011 Cheltenham, MD Signature of Funeral Service Licens 22. Name and Address of Facility Briscoe-Tonic Funeral Home Old Washington Rd.Waldorf, MD 20601 2294 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each of the death. Immediate Cause (Final Wiscas Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Cause (Disease or in that initiated events burial-trar resulting in death) Last physician Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Por Month Day Pregnant at time of death signed by the at d be detached for Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 death? 2 🗆 No Yes funeral director, 25. Was case referred to rp Medical Certificate: To Be 26. Place of Death (Check only one) examiner? lospita Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this To the recognition within 24 hours after death.

To the Funeral Director: After the state of the funeral of the 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🔲 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one the cause(s) and manner as stated 29c. License number 30. Name and address who completed cause of death (Item 23a) (Type. Print)

State Registrar Registrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mary		artment of H		d Mental Hy	giene	and the first state of the stat			
	_		Registrar 1. Decedent's Name (First, Middle, Last)		T	Reg. No. 2 3 5							
П	Physicia		Lola C. Rennie					Month	Day Year	3. Time of Death 3:25 P M			
Se v	Medic Examir		4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, or	Location of D	October Death	23, 2011 4c. County of De				
met.)		Southern Maryland	Hospital		Clinton			Prince George's				
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt		Birthplace (State or Foreign Country)			
	Director			M 2 X F	90 Yrs.	Wionth's Days	Tiouis I	Feb 23,		enver, Co			
	nd how at	<u> </u>	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	cation		100 20,		10d. Inside City Limits			
	laryla 3a-f s ified	ect	Maryland Prince Geor	ge's	Car	mp Springs				1 ☐ Yes 2 ☐ X No			
	or 28	<u></u>	10e. Street and Number	8		10f. Zip Code			10g. Citizen of What 0	Country?			
	with s 23a ust b	Funeral Director	6709 Berkshire Dri	ve			20748		United St	ates			
	death item		11. Marital Status	2. Was Decedent Ever Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Ori <i>g</i> in'	(Specify Yes or No- uerto Rican, etc.)		nerican Indian,			
36	after I", or xamir	l by	1 Never Married 2 Married	1 Yes 2 No		☐ Yes 2√√ No			Black, Wh				
9	ours atura	Completed	3 Widowed 4 Divorced	Year or Dates.		ent's Usual Occupa				White			
15	72 h an "na Media	шb	(Specify only highest grade	completed)	(Give k	rind of work done d O NOT use retired)		working	16b. Kind of Busines	ss/Industry			
212	withir giene er tha		Elementary/Secondary (0-12)	College (1-4 or 5+)		memaker			Own Home				
pu	filed al Hy d oth	o Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Surname)				
yla	Ment marke	잍	Lawrence Cripps				Ruby	y Peterson					
Mai	shouth and hand 7 is n		19a. Informant's Name/Relationship (Type		101				; City or Town, State, 2				
e,	and Healt		Susan D. Rennie (Daugh 20a. Method of Disposition		428 N Ob. Place of Dispos		Street		ndria, Virgir				
nor	age 1 ant of tr. If it		1 ☐ Burial 2 X Cremation 3 ☐ Re		cemetery, crem	natory or other place		Date	20c. Location - City	or fown, State			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Sig v ture of Funeral Servive License		Lee Crema				Clinton, MD	00 011 411-4-			
ä	permit Depar Impor any ir		Tous of the	A mon	257 F	erry Road,	Clinton	MD 20735	Home, Inc box	33 Cld Alexandria			
E			282 Par 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the						Approximate Interval Between			
	husician/	8 8	Immediate Cause (Final disease or condition	ACUTS	(FR	SPAN	ACCUI	AR ACC	INGNIT	Onset and Death			
	Medical Examiner		resulting in death)		nsequence ot):			2					
		ē	Sequentially list conditions, if any, leading to immediate			RATOR	1 1	TIWRE					
	ed	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	TENS/	α 11	0/60						
	xecut n and al-tra	Еха	that initiated events c. resulting in death) Last	Due to (or as a cor	nsequence of):	<u> </u>	900	<u>C7,</u>					
09	ate be executed ohysician and the burial-transit	dical	d.										
876	tificate ng phy as th	Med	IF FEMALE:										
Box 687	eath certificat attending ph	ian/	23b. Was decedent pregnant in the past 12 months?	i. If yes, outcome of pr 1 ☐ Live Birth 2 ☐	Fetal death 3	Ectopic pregnancy	/		23d. Date of o	*			
Bo	e deat the at hed fo	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	e of death 5	Other (specify)			Month	Day Year			
P.O.	nat the ed by detac	Ph	Part II. Other significant conditions conti	ibuting to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
s, F	ires the signer signer in the signer in thes	d by						1 🗆 '	/es 2 □ No 3 □	Probably 4 Unknown			
ord	/ requ	lete						24a. Was a	an 24b. Were a	autopsy findings available			
1 Yes 2 No 3 24a. Was an autopsy prior to death autopsy prior								completion of cause of					
<u>a</u>	an; T tifical tor, p	o l	25. Was case referred to medical			26. Pla	ce of Death (0	1 L Yes Check only one)	2 No 1 L Y	es 2 No			
Ž	ysici is cel	To B	examiner? 1 \(\superset \text{Yes} \) 2 \(\superset \text{No} \)	spital: 1Inpatient	2 ER/Outpatien	t 3 🗆 DOA Othe	r: 4 🗌 Nursir	ng Home 5 - Resid	ence 6 Other (Spe	ecify)			
o	frer th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Yea	28b. Time of injury	28c. Injury work?		28d. Describe h	ow injury occurred				
ou	tendi death tor; A the f	iţi	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 ☐ No						
Division of Vital	or At after of Direc	Certificate:	4 Homicide determined	28e. Place of Injury - building, etc. (Sp.		et, factory, office			ation (Street and Number or Rural Route Number, or Town, State)				
Ω	spital	ical	29a. Certifier 1 Certifying Physici	an: To the best of my k	nowledge, death o	ccurred at the time.	date and pla	ce, and due to the ca	use(s) and manner as	stated.			
Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Du								place, and due to the cause(s) and manner as stated. surred at the time, date and place, and due to the cause(s) and manner stated a and place, and due to the cause(s) and manner as stated.					
	Vith Com	_	29b. Signature and title of certifier	9)	29c. License	number		29d. Date signed (Mor	nth, Day, Year)			
			KASHEGIADA	551 - 15		MD	653	29 (CTOBER	24 2011			
	10 DC		30. Name and address of person who com	pleted cause of plath			-, 0			UN ONTOT			
	Stat	_	31. Date filed (Month), Plan Year) 6 201	32 Aegistrar's S	7503 ₂	SURRATT	7 K	40. CL	1~10~ 1	40 20735			
	Registra	ır	31. Date filed (Month, Car Year) 6 201	Cours	- / /	the							

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			For State Registrar	State of M	larylan		artment o			nd M		ienez	2011	360)55		
			Decedent's Name (First, Middle, Last)				_		-		2. Date of Deal	h Day	Year	3. Time of	Death		
	Physici /Medi		Shirley Lorrai	ne Ro	we						10	24	20111	7:41	P^{M}		
Î	Examir		As Early M. March Co.						ocation of	Death		4c. C	ounty of Death				
			11 West I Street					nswi		7 Usa			ederick				
	Funeral Director		5. Social Security Number 6. Sex 1□	4 35 5	ge (In yrs.	last birthday) Yrs.	If Under 1 \ Months D		Hours	Min.	8. Date of Birth 8/27/15	$48^{\gamma_{\it par}}$	9. Birthp Coul Mary	place (State of Tand	r Foreign		
	Đ .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											04 114- 01			
17215-0036 within 72 hours after death with the Maryland	anylar ehov	<u>_</u>	10a. State 10b. County											10d. Inside City Limits 11€ Yes 2 □ No			
	he M	Director	MD Frederick 10e. Street and Number			Brunsw						n of What Cou					
	with 1										'		ISA	itry ?			
	leath	era	11 West I Street	2. Was Deceden	t Ever in U	.S. 13. V				in? (Spec	cify Yes or No-		. Race - Americ	can Indian,			
	be filed within 72 hours after death with the Marylar lat Hygiene. Id other than "natural", or items 23a or 28a-f ehow other than "natural", or items 23a or 28a-f ehow event, if a Medical Evar it act must be notified at	Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 127 No							Puèrto F	cify Yes or No- Rican, etc.)		Black, White, etc.				
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N D	tygi her nt, I		17. Father's Name (First, Middle, Last)			onepp	ara ii				(First, Middle, I						
land		To Be	James Henry King								aret Br						
2 달	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type	e, Print)		19b. Mailin	g Address (S	treet and	d Number	or Rurai	Route Number	, City or T	Town, State, Zip	Code)			
	122를로		Mary Taylor, Sister	•		P.O.	Box 3	16,	Ripp	on,	WV 2544	.1					
ore	of Hea of Hea fitam r othe		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Re	moval from State		Place of Dispo- cemetery, cren	sition (Name natory or othe	of r place)			A	20c. Loca	ation - City or To	own, State			
Ĕ	Pag ment tant: I		'4 □Donation 5 □ Other (Specify)	movar nom state		gerstown	Cremato	ory	10	0/27	711	Hagen	stown Mar	yland			
Baitimore,	permit. Pages to Department of Huportant: If its any injury or of once.		21. Signature of Funeral Service Licenses	en-			Name and A				Home, Bri	nswic	k MD 21	716			
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	Physician		Immediate Cause (Final disease or condition					A	sti	in	a			Onset and D	eath 5		
	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):								, 0.00			
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	that the death certific ed by the attending p detached for use as	hysician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								MOIIII	Day 1	ear			
ŗ	that the side by detac	۵	Part II. Other significant conditions conti	ibuting to death	but not res	ulting in the ur	nderlying caus	se given	in Part I		23e. Did tobacco use contribute to the cause of de						
cords,	The law requires that the sate has been signed by the bage 2 should be detache	ed by										es 2 🗆			nknown		
))	law re as be 2 sho	Completed									24a. Was a		24b. Were auto	opsy findings a	available		
<u>כ</u>		No.									perform		death? 1 ☐ Yes	2 No	1030 01		
ומ	clan: ertific actor,	Be (25. Was case referred to medical examiner?					2	6. Place	of Death	(Check only or	e)					
5	hysi this c	ပ္	Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 ★ Residence 6 □ Other (Specify)									fy)					
5	ding F h. After funer	ertification;	27. Manner of Death 1	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	28c.	Work?	t s 2 ⊟N		8d. Describe h	ow injury	occurred				
2	I or Attandi after death. Director: A	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir	iury - At bo	ome farm stre			3 2 11		8f. Location (S	reet and	Number or Run	al Route Num	ber.		
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	To the Hospital or Attanding Physician: To the Funeral Director: After this certific To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) Check only one)	cian: To the bes	of examina	wledge, death	occurred at trestigation, in	the time, my opin	date and ion, death	place, a	nd due to the c d at the time, d	ause(s) a ate and p	nd manner as s lace, and due t	stated. o the cause(s))		
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	4		30. Name and address of person who com	pleted cause of	death (Item	n 23a) (Type,	Print)	-1	4		/	_	1 .	/			
	~	2	Hlan Kohrer, 1	ND, DI	YE,	15 W	est	10	-5	tre	et, Fr	ed	erick	MD2	1701		
	Sta	200	31. Date filed (Month Day, Year) 201	2. Pegist	rar's Signa	iture	,				/		,	7-1	₩; 19		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 29c per DVR G921 11/17/11 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 27 VIRGIL STEYER, JR. 2011 11:05 P 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OAKLAND NURSING & REHAB CENTER OAKLAND GARRETT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/23/1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F STEYER, MD 78 Director 217-28-9710 Usual Residence of Decedent within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertalt Hygiene. Important: If time Z7 is anarked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Maritan Evaminer must be notified as Director 1 Yes 2 □ No MD **GARRETT** OAKLAND 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 706 ALDER STREET 21550 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐Yes 2XNo Specify. p Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS RETAIL MANAGEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VIRGIL T. STEYER, SR. NELLIE P. GRIMM 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY STEYER (SON) 420 SONNY DRIVE, OAKLAND, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State WVU MEMORIAL VAULT 4 Donation 5 ☐ Other (Specify) 10/28/2011 MORGANTOWN, WV 21. Signature of Funeral Service 22. Name and Address of Facility WVU HUMAN GIFT REGISTRY PO BOX 9131, MORGANTOWN, WV 26506 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 12965 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting if the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical 29a. Certifier Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and fitle of certifie 29d. Date signed (Month, Day, Year) 29c. License number н64705 0,28.11

State Registrar 30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print)

106

NOV

31. Date filed (Month, Day, Year)

Alder

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Kailer Stubler, Sr. 10:45^M November 02, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Grantsville Garrett 5. Social Security Number Funeral . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **X** M 2 □ Days Months Hours Min 214-88-0321 Director 47 November 14, 1963 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "nature." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Garrett 1 Yes 2 No Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 891 Dorsey Hotel Road 21536 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Chemical Storage Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Stubler, Jr. Margaret Lee Heier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Kailer Stubler, Jr.- Son 175 Pysell Road, Unit 25, McHenry, Maryland, 21541 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory Cumberland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 04, 2011 Signature of Funeral Service Licensee 22. Name and Address of Facilify Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown signed by t t be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? performed. 1 Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Investigation Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 0 Date filed (Month, Day, Year) Registrar's Signature State 1 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 10/24/2013 1:15 P CARRIE LEONA SNOWDEN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Cherry Lane Nursing Center Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 Days Hours Mir Months 85 **Director** 04/30/1926 220-24-2278 Usual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Howard Laurel MD 10e. Street and Number 10f. Zip Code Citizen of What Country? 10g. Cit Funeral 20723 9889 Harmony Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married þ 1 Yes 2 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Domestic House Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ Estella Snell James Snowden permit. Page 1 and 2 should be Department of Health and Men Important, If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9889 Harmony Lane, Laurel, MD 20723 Debra Ann Chambers/niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Nat'l Mem Pk 10/29/2011 | Laurel, MD 4 Donation 22. Name and Address of Facility 21. Signature of Dineral Service Lice Snowden Funeral Home una. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer ver 1 year Immediate Cause (Final disease or condition resulting in death) Physician/ Alzhiemer's Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Box 68760 the as IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months? jo Day Pregnant at time of death the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Arteriosclerotic Cardiovascular Disease Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law page 2 s autopsy performed? Yes 2 XNo within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 **X** No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending work 1 Yes 2 No M Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Akbar Sediq, MD

31. Date filed (Month, Day, Year)

OCT 2 7 2011

D24721

14333 Laurel Bowie Road, #208, Laurel, MD 20708

10/26/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36059 State Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 Eva S. Steuer October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring Homecrest Assisted Living <u>Montgomery</u> Silver Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Country) **Director** 577-48-7436 1 □ M 2 👿 F Usual Residence of Decedent 11/26/1910 100 New York 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland at Director 'natural", or items 23a or 28a-f sl dical Examiner must be notified 1 X Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14514 Homecrest Road 20906 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify 3 X Widowed 4 Divorced ted White Medical Complet Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed, life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the US Government 9 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nathan Sobin Ida Ilman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 <u>Adele Fishbein / Daughter</u> Arctic Ave. Rockville, MD 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If it
any injury or of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, cr ematory or other place) Judean Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 10/23/2011 Olney, MD 22. Name and Address of Facility Danzansky-Goldberg 1 1170 Rockville Pike Signature of Funeral Service Licenses once. MO1477 Memorial Chapels Inc. Rockville, MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed and a resulting in death) Last Due to (or as a consequence of) physician the buriar Physician/Medical P.O. Box 68760 attending p IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Month Dav Year Pregnant at time of death Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Records, been signated the beautiful the should the s 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed certificate 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Hospital Other: 1 🗌 Yes ျပ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred After 1 X Natural 5 Pending within 24 hours after death

To the Funeral Director:

completely filled in by the Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and little of o 29d. Date signed (Month, Day, Year) 10 October 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr., #211 Silver Spring, MD 20906 3801 <u>International</u> Gova1 M.D. 31. Date filed (Month. Da State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Of Mary 10 State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lenorc G. Schwartz 0300 A M Medical 20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomera Hobrow Home of Greater Washingto ROCKVITE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F 064-26-0492 Days Hours Min. 11971971927 New York 83 **Director** Usual Residence of Decedent or 28a-f shov 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Rockville 1 K Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6121 Montrose Road 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes Give 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Secretary US State Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Schwartz Belle Kurtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvyn Schwartz-Brother 327 Knotty Pine Circle, #D2 Greenacres, FL 33463 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesed Shell Emes 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/23/2011 Capital Heights, MD 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee Molly 3 Tail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ancreatic cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) o the Hospital or Attending Physician: The law requires that the death certificate be executed thin is thours after death.

Ithin 24 hours after death.

Ithe Funeral Directors. After this certificate has been signed by the attending physician and propeled filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Fibrillation 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No 2 1 N Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Tuun R172412 10/21/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.JCfferson St. ROCKVILL MD 20852 31. Date filed (Month, Day, Year UCT 2 7 Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 22, 2011 Howard C. Simms Sr. 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7802 Marwood Drive Prince Georges Clinton If Under 1 Year If Under 24 Hrs 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min June Pay. 220-34-3015 Washington, DC Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Prince's Md Clinton 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 8604 Temple Hill Rd. 20735 USA filed within 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mex life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tile Mason, Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Augustus Thompson Margaret Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4010 Kathland Ave. Baltimore, Md. 21207 Howard C. Simms (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place, Lincoln Memorial 1 X Burial 2 Cremation 3 Removal from State 10/28/11 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, INC 6633 Old Alexandria Ferr Rd. Clinton, Md 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed^a 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 🗀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral Completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DC

State

Registrar

29b. Signature and title of certifier

(VA

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Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2 October 2011 5:50A M Xavier Murphy Smith Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice of St. Mary's Callaway Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Birthplac Country) MD 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday Months Days Hours Min. 1 🕱 M 2 🗆 4 / 11 / 1938 Director 215 38 5168 73 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City. Town or Location the Maryland 10d. Inside City Limits Funeral Director notified 1 Yes 2 No St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? pe ms 23a must be 40430 Kavanagh Road 20659 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black White etc 1 X Never Married 2 ☐ Married ٥ þ Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Completed er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, th 8th Custodian County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Hitem 27 is marked of other traumatic even မ Joseph W. Smith Margaret Teresa Dyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L.Brown/ Sister 39250 Birch Manor Dr. Mechanics ville, MD20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o ent of XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/28/2011 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Charles Mem.Cem. 22. Name and Address of Facility Briscoe-Tonic Funeral 21. Signature of Funeral Service Licenses Home 2294 Old Washington Rd.Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not entur the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequant e of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ for in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a 1 Yes 2 L 9 Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1

✓ Yes 2

No 3

Probably 4

Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 Other (Specify 2 XNo Hospital: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral 28d. Describe how injury occurred Mous Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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ed cause of death (Item 23a) (Type, Print)

Registrar's Signature

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	# # # #		Susan Senkow—A] 20a. Method of Disposition	<u> Len (Daughter</u>			Elizabetl sition (Name of	ı Court	4	apeake B o Date		D_20/32 ition - City or	Town, Star	te	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:45 P M October 25 201 1 201 Bobby J. Speight Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Fort Washington Prince George's 5. Social Security Number Funeral Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗷 M 2 🗆 F Months Hours July 18, Year 1952 578-74-4475 59 North Carolina Director Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🖺 Yes 2 🗌 No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1100 Owens Road # 202 20745 United States death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛂 No 1 Never Married 2 Married ld be filed within 72 hours after Mental Hygiene. Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 A No Specify If Yes, Give Year or Dates Specify: American 3 🖁 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Laborer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ Augusta Speight Addie Jane Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Speight - Son 5600 San Juan Drive Clinton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State October 2011 4 Donation 5 Other (Specify) Lee's Crematory Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Tun Benning Road NE Washington, DC Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onliet and Death h sician/ disease or condition Medical resulting in death) Due to (or as a consequent of): Examiner Fibrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami STAG Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequen physician a s the bunal-Medical Box 68760 attending p IF FEMALE: Physician/ 23b. Was decedent pregnant es, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? Month Day ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. nas been signed be 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 1 🗌 Yes 2 No 1 Yes 2 Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospita 1 🗌 Yes 2 욘 Other: Inpatient 2 this ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 \sum Yes 2 \sum No hours after death.

neral Director: Aft

filled in by the fur Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/ar inventional and a state of the cause of the 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year, 22 5950200 10 men 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel J. Kleiman MD 11701 Livingston Road Fort Washington, Maryland

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

OCT 2 8 2011

I or Attending Physician: The law requires that the death certificate be executed after death. use as the burial-trar attending physician detached 2 cate has been signi page 2 should be o certificate this funeral After neral Director: A filled in by the fu

the Maryland

filed within 72 hours after death with

21215-0036

Maryland

Baltimore.

28a-f show

Items 23a or

6

'natural"

3 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

Pages 1 and 2 s ment of Health ar 27

= 5

traumatic event, the Medical Examinar must be notified at

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a To the Funeral I TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Au Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and fifte of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0064208 October 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saadi Hussain MD 4409 East West Hwy, Riverdale, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 8 2011

4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $6, \frac{1}{2} 011$ PAUL JOHN STOCKS NOV -4:50A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES WALDORF 2377 ASHFORD DRIVE Social Security Number If Under 1 Year __ If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11-16-1937 Months Days PA. Hours 235-54-9628 73 **Director** Usual Residence of Decedent ems 23a or 28a-f show er must be notified at 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WALDORF MD. CHARLES 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2377 ASHFORD DRIVE 20603 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. traumatic event, the Medical Examiner Armed Forces?

1 Xes 2 No NAVY
If Yes, Give Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates KOREA 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) NAVALRESEARCH LAB. Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRONICS ENGINEER U.S.GOVT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ MILDRED MAY WILLIAMS PAUL JAMES STOCKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code WALDORF, MD. 20603 2377 ASHFORD DRIVE SANDRA STOCKS-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY ALEX., VA. 22 Name and Address of Facility
RAYMOND FUNERAL SERVI
LA PLATA, MARYLAND 206 M0047 21. Signature of Furieral Service Licensee Part 1. Enter the disease, or complications the sau shock, or heart failure. List only one cause on each aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ OV Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury **⊟**Natural 5 Pending 1 🗌 Yes 2 🗌 No _ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 31. Date filed (Month, Day, Year, State NOV 1 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36067 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **OCTOBER** 14:17P M 2011 ROBERT LEWIS THOMAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Hours 1 X M 2 🗆 F SPITMBER 12.1942 MISSISSIPPI 69 425-94-4854 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at the Maryland Director 1 X Yes 2 No MARYLAND CHARLES PORT TOBACCO 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20677 UNITED STATES 6220 HAMPSTEAD COURT death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or is any injury or other traumatic event. the Mental "natural", or is once. 1 Never Married 2 X Married þ 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DEPUTY OF CRIMINAL INVESTIGATION FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ MAGNOLIA L. THOMAS WILLIE AVERY THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6220 HAMPSTEAD COURT, PORT TOBACCO, MARYLAND 20677 JUANITA L. THOMAS / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State cemetery, crematory or other place) BRINSFIELD-ECHOLS CREMATORY OCT. 29, 2011 CHARLOTTE HALL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
2420 TUTNESTON ROAD, INDIAN ture of Funeral Service Ligenses LYDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, HEAD MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sudden Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year Day signed by the at d be detached for 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 A No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 🗆 Inpatient 2 🗶 ER/Outpatient 3 🗆 DOA 27. Manner of De fil 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation filled in by the 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title certifie 29c. License number 30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)

Registrar

State

Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2011 06:22 Betty Jane Veasey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 E1kton 303 Hollingsworth Manor If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth Aug. 12, 1923 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 88 Wisconsin **Director** 216-18-4598 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 10a. State 10c. City. Town or Location 1 X Yes 2 ☐ No Elkton Maryland Ceci1 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Funeral United States 303 Hollingsworth Manor 21921 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes 2 X No Specify. Specify: White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plastics 4 1 Line production worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Unknown Spencer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Trina Veasey/Daughter 303 Hollingsworth Manor, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State November 7 Cherry Hill Methodist Cem. Cherry Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signa ure of Funeral Service Licensee 21921 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a onsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ₪ g ☐ Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed' 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 🗌 Yes 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d Describe how injury occurred work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending __ vatural

Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 65902 MN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CANU GEFET 138 Catheura Cathedred St. Elkton MO 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State

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Registrar

2011

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36069 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October. 7:00 pm Alezah Weinberg 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 8100 Connecticut Avenue. Chevu Chase 8. Date of Birth (Month, Day, May 18 Birthplace (State or Foreign Country) Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 1 M 2 K F Hours Director 301-14-8473 86 Ohio Usual Residence of Decedent show important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 U.S.A. 8100 Connecticut Avenue. #512 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married Completed by 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Jewish Family College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Clinical Social Worker <u>Service Agency</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dora Kutnick Louis Dworkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9212 Watson Road, Silver Spring, Maryland 20910 Naimah Weinberg - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🕱 Removal from State 4 Donation 5 Other (Specify) 10/28/2011 Cleveland, Ohio Zion Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home M00707 11800 New Hampshire Ave., Silver Spring, MD20904 Tary 23a. First 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cerebral Vascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) Yes 2 X No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Hypertension 1 ☐ Yes 2 📝 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Severe Cervical and Lumbar Stenosis 24a. Was an Jas autopsy performed? Yes 2 1 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: After maniple of filled in by the fun Division Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 10 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 26. 2011 D55258 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7758 Wisconsin Avenue, #211, Bethesda, Maryland 20814

Registrar DHMH 17 Rev 7/2009

State

Gary B. Wilks,

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HELEN LEWIS WATTS 2011 :30 PM OCT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11014 Stillwater Avenue Montgomery Kensington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F Days Hours Min SEP 14 226-42-3783 89 **Director** Yrs Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No MD Montgomery Kensington 10e. Street and Number 10g. Citizen of What Country? 9 ms 23a or must be r 20895 Funeral 11014 Stillwater Avenue United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Caucasian "natural" 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Teacher Education 18. Mother's Name (First, Middle, Maiden Surname)
Reese Be 17. Father's Name (First, Middle, Last) ည George Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean A. Gentile / Cousin 3 Saw Creek Estates, Bushkill, PA 18324 20a. Method of Disposition
1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Atlantic Crematory 10/25/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Thibadeau Mortuary Service, p.a. M00956 Park Avenue, Gaithersburg, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MYELODYSPLASTIC SYNDROME disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and D. Due to (or as a consequence of): attending physician I for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Be Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 No 2 🗌 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛂 No Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify, ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🙆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar MICHAEL

Α.

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WESTERMAN

\$2. Registrar's Signature

D52451

WRNMMC

BETHESDA MD 20889-5600

October 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#20bperfuneralhome10/25/2011c Cantificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 23, 8:15 201°° Beryl Α. White p.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Charles **Examiner** 4b. City, Town, or Location of Death 2950 Fern Hill Place Waldorf 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F Months Hours May 8 Pay, 1911 100 040-48-5192 Yrs Director Jamaica Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 XNo Maryland Waldorf Charles 莅 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2950 Fern Hill Place 20602 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Her Home Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alexander Thompson Ophelia Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 20602 Department of Health Important: If item 27 any injury or other tr 2950 Fern Hill Place, Waldorf, Maryland Mavis Payne Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Dovecot, St. Catherine, JA. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other placeNOV 4 Donation 5 Other (Specify) Dovecot Cemetery 5, 2011 Oct. 21. Signature of Funeral Service License Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, M00668 20640 23a. Part 1. Enter the shock, or hear disease, or complications that caused the death. Do not enter the Approximate nterval Between nset and Death de of dying, such as cardiac or respiratory arrest failure. List only one Immediate Cause (Final disease or condition resulting in death) Phylician CN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence off. Exami burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires t 24 hours after death.
Funeral Director, After this certificate has been sign Division of Vital Records, 1 Tes 3 Probably 4 Unknown No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes 2 No Yes 2 completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify Daughters ည 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
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Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 No Investigation Accident 6 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and tine 29d. Date signed (Manth, Day,

DHMH 17 Rev 7/2009

State Registrar

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Registrar's Signatu

11-08206 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Joseph Arthur Wilson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day November 2, 2011 0645 hrs **Medical Examiner** 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Western Maryland Health System Cumberland Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Foreign Months Days Hours Director 1 M 2 F Yrs 4-62-4087 Usual Residence of Decedent 10d. Inside City Limits Ā 10a. State 10b. Count 10c. City, Town or Location 1 Yes 2 No s 23a nr 28a-f show e notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", ar items 23a ar 23a-r sho ra nather transatic event, the Medical Examiner must be notified at once. Mariland Director 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country? Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number of Rural Route Number, City EIKHEK ROOCH More Frostbi Lones Joseph 1 20b. Place of Disposition (Name of cemetery, Date 20s. Pocation - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Vovember Department C Cemeter Moscowillis 4 Donation 5 Other Specify: 22. Name and Address of Facility & East main Street Langtonia 21. Signature of Funeral Service Licenses holm hom McKenzle Funeral Homo mas Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Smoke Inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed has been si 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? 1 🗸 Yes certificate director, page ✓ Yes 2 No Hospital nr Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) NoV 2, 2011 After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Subject involved in housefire 0650 hrs 1 Yes 2 ✔ No within 24 hours after death.

To the Funeral Director: Director: 5 Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in ! 3 6 Could not be Suicide or Town, State) 14802 Railroad Street, Midland, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

aska

29c. License number

OCME

OCME

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

November 3, 2011

and manner stated.

who completed caus of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifler

31. Date filed (Month, Day, Year) **NOV 1** 0 2011

Theodore M. King, Jr., MD.

I-08220 athleen J. Wils		Please Type or Print in Black Indelibl State of Maryland / Department Certificate Certificate	es Are Legi ygiene Reg.	2011 3607						
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month D	3. Time of Death					
ledical Exami		4a. Fecility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November 2	2, 2011 2017 IIIS					
7		Western Maryland Health System	Cumberland		Allegany					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs Months Days Hours Min.	-	MM/DD/YYYY 9. Birthplace (State or Foreign Country)					
MD and 2 st alth an m 27 i	mpleted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1 10b. County 10c. City, Town or 1 11c. Marital Status 12c. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 11c. Per Newer Married 2 Married 11c. Proceed If Yes, Give Year or Dates: 11c. Decedent's Education (Specify only highest grade completed) 11c. Decedent Specify Only highest grade completed Only high	alling Address (Street and Number of Failing Address (Street and Number of Failing Address)	vork done 1 red) 1 (First, Middle, Ma	er, City or Town, State, Zip Code)					
Baltimore, Sch pemit Pages I ar Sch Department of Hee In portant: If ite	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Smoke inhalation and thermal Due to (or as a consequence of): b.	22. Name and Address of Facility S & Exhand My Motore Funter the mode of dying, such as cardiac of	2011 I	0 KA. May md 27535					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED AMENDED Due to (or as a consequence of): d. AMENDED 23c. If yes, outcome of pregnancy			23d. Date of delivery					
. Box 68760, the death certificate be ex y the attending physician the for use as the burial.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 1 Live birth 4 Pregnant at time of death 5 Unknown 2 Unknown 2 Contributing to death but not resulting in	Fetal death 3 Ectopic pregna Other (Specify)		Month Day Year acco use contribute to the cause of death?					
ords, P.O. w requires that the as been signed by t should be detache	Completed by			24a. Was an autopsy	prior to completion of cause of					
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Vital Rec ynician: The b his certificate I director, page	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outp	26.Place of Death (Check atient 3 DOA Other Marsin		esidence 6 Other:					
Division of Vital Records, talor Attending Physician: The law requirers after death. *I Director: After this certificate has been sided in by the funeral director, page 2 should be a by the funeral director, page 2 should be a by the funeral director.	ion: To	Tes 2 No	ne of Injury 28c. Injury at Work?	28d. Describe ho						
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	2								
the Host hin 24 hc the Fun apletely f	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigation.								
J W To or	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. OCME November 3, 2011								
1 /1		·	er 900 W. Baltimore Street, E	Baltimore, MD	21223					

State 31. Date filed (Month, Day, Year) istrar NOV 1 0 2011 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Allen Belslan Medical November 01 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Marley Neck Rehabilitation Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign-Country) (4 N K 1 444) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Days 240-36-823 Months Director 28a-f shov 10a State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits must be notified at **Funeral Director** ANNE ARUNDEL GIEN BURNIE 1 Tes 2 No 10f. Zip Code ō 10g. Citizen of What Country? 23a U.S.A 7575 E. HOWARD ROAD 21061 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ō Completed by 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced BLACK Specify: "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than "r traumatic event, the Med most of working Elementary/Seconday (0-12) College (1-4 or 5+ Domestic Worker House Keeping Be 17. Father's Name (First, Middle, Last) (HWKY) 18. Mother's Name (First, Middle, Maiden Surname) (Cinc) ည Amos Egerton Virginia (Unkown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a MULLINS Robert PEE 3606 Hill Rd., South CAROLINA other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Number 1 Surial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MARYIAND 11/19/2011 4 ☐ Donation 5 ☐ Other (Specify) TRINITYCEMETERY 22. Name and Address of Facility The DERRICK C. JUNES FIH, P.A. 21. Signature of Funeral Service 50 PARKHGIS, ANE., BALTIMURE MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovascalar Immediate Cause (Final Physician/ Alkero Sclenolic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Bullahin mai To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: . If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No g Unknown g | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural iniury 5 Pending work 1 🗌 Yes 2 🗆 No Acciden Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 1) 3064 November 8 (ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rameh Sabapathi Lol-109 Back RWW WOLL Road Balhmore Mayladzizz Sabapally 31. Date filed (Month, Day, 32. Year, State arke Registrar

DHMH 17 Rev 7/2009

			Please ar	Type or Print in	Black Indel	ible Ink. Ensu 8921 11-14-	re All Copic	es Are Legible).
			1 - For State Registrar	Type or Print in mend item 1 State of Maryla AMEND TIEM#	29é PHYS', G Certifica	9722,1775726 ate of Death	19 ;\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ygiene Reg. No. 201	1 36075
ı	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of D	Death Day 10 Year	3. Time of Death
- 4	Medi Examir		4a. Facility Name (if not institution, give si	treet and number)	4b. C	ity, Town, or Location of I	Death	4c. County of De	ath
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	7302 Kenns	2. Was Decedent Ever in		cedent of Hispanic Origin	21244 ? (Specify Yes or No	US/H D- 14. Race - Am	nerican Indian,
36	after d al", or ir Examine	٤	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		pecify Cuban, Mexican, F 2 No Specify:	Puerto Rican, etc.)	Black, Wh	
21215-0036	72 hours "natur edical E	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's U	work done during most of	f working	16b. Kind of Busines	s Industry
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type			ess (Street and Number of	7 7	per, City or Town, State, 2	A A
	1 and 2 of Health item 27 other to		Nelle FTT hur 20a. Method of Disposition	20b.	Place of Disposition (A		Date Date	20c, Location - City of	r Town, State
Baltimore,	it. Page rtment o rtant: If njury or		1 ☐ Burial 2 🗹 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Jemetery, crematory of	lount 11	1-21-201	13a/4in	nove MD
Ba	permit. Departri Importa any inju		21. Signature of Funeral Service Ligense	have	22. Name 873	and Address of Facility 8 Liberty A	Road Ro	areene Fune	myd1133
١,			23a. Part 1. Enter the disease, or complic shock, or hear failure. List only one Immediate Cause (Final	cations that caused the dea cause on each line.	th. Do not enter the m	ode of dying, such as car	rdiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	mysician/ Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	puence of):				Shock and Boath
		ner	Sequentially list conditions, b	Due to (or es a consec	uence of:				
	e executed cian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseq	Hence off:				
00	E - E - E	-	d d						
68760	certifica nding ph use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	ic. If <u>ye</u> s, outcome of pregna				23d. Date of d	eliveny
Box	e death the atte	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown				Month	Day Year
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ords,	been si	Completed					1 □		Probably 4 Unknown utopsy findings available
Records,	The law ate has page 2 :	Comp					— aut	opsy prior to death?	completion of cause of
/ital	/sıcıan: s certific lirector,	To Be (25. Was case referred to dical examiner? 1 ☐ Yes 2 ☐ No Ho	ospital:	ER/Outpatient 3	26. Place of Death (Check only one)		
Division of Vital	ung Pny n. After this funeral c		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe	sidence 6 Other (Spe how injury occurred	icity)
/ISIOI	r Attence er death rector: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factor	1 Yes 2 No	28f. Location	(Street and Number or R	ural Route Number,
	spirar or rours aft reral Dir filled in		29a. Certifier 1 Certifying Physici	ian: To the best of my know		at the time, date and place		own, State)	tated
D	the nos thin 24 h the Fur mpleted	Medical	(Check 2 Medical Examine	r: On the basis of examinatio	n and/or investigation, i y kholilladga death oo	n my opinion, death occur curso at the time, date un	rred at the time, date	and place, and due to the	cause(s) and manner stated.
	0 14 € 0		29b. Signature enortitle of certifier	17)	2	9c. License number	-O	29d. Date signed (Mon	
	2		30. Name and address of person who com		n 23a) (Type, Print)	1 Randalls			V) / - 11
	Stat	_	1anveer (a) 54 31. Date filed (Month, Day, Year) NOV 1 4 20	32. F. gistrar's Signa	ture		iwio p	10155	
	Registra		MOAT 4 50	11 Seven	A. Maure				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 09, Rachel 2011 12:45 PM Linda Anderson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Baltimore Rossville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 1 ☐ M 2**XX**F Months Days West Virginia 10/07/1938 234-64-6622 Director 73 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director W. VA. Mercer Princeton 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 Elmer Street 24740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ ☐ Yes 2**XX**No Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2XXNo Specify. Completed 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) olth and Mental H 27 is marked of r traumatic ever 2 Lon Gilmer Jean Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,23140$ Department of Health ar Important: If item 27 is any injury or other trau Dale Anderson (Son) 12707 Sterling Heights Ln., Providence Forge, Va. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11/10/2011 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern AVenue, Essex, Maryl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ck, or heart failure. List only one cause on each line ate Cause (Final diate Cause (Final Onset and Death (ELL CARCINOMA Physician/ ease or condition esulting in death) Medical Examiner Sequentially list conditions cause. Enter Underlying Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death P.O. by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The Lawithin 24 hours after death.

To the Funeral Director, After this certificate h performed 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hour after death.
Funeral Director After thi
eted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending iniury Division 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completed filled Medical 29a. Certifier check ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Presturer: To the best of my knowledge, continued at the lime, date and place, and due to the cause(s) and manner as stated. only one 296. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 10,2011 D0060560 s of person who completed cause of death (Item 23a) (Type, Print) ROSEDALE, MD 9106, # 208

Registrar

State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DOI Medical 1a. Facility Name (if not institution, give stre Examiner Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Funeral Social Security Number 8. Date of Birth Country) K<u>ansas</u> 1x x M 2 □ F (Month, Day, 0-05-1 493-58-6645 Director Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits by Funeral Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 24 No MD Baltimore Catonsville 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 27 Dunbar Avenue 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian. Armed Forces 1√√ Yes 2 □ No 1968 If Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed 1970 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Steel Manufacturer Steel Press Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Manue1 Alvarez Hazel Elizabeth Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Alvarez - wife 27 Dunbar Avenue, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Meadowridge Mem Park :11-14-2011 4 Donation 5 Other (Specify) Elkridge, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line? Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition SdAV S) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Day Year signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No. has been s le 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe the Hospital or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director; Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29b. Signaty 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reave Street Baltimore MD 21201 MezzadRA

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 9 2011 Physician/ ADAMS 6:58 P M THOMAS JAMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours DEC. 20 242-42-1887 1 XM 2 - F NORTH CAROLINA T929 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No WASHINGTON DC10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20001 USA # 322 461 H STREET N.W. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12TH RAILROAD ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည TALBERT LILLIE ARTHUR ADAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3909 CLAIRTON DRIVE MITCHELLVILLE, MARYLAND 20721 SAM O. WILLIAMS/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burier 2 Cremation 3 F 4 Donation 5 Other (Specify) Removal from State TRIANGLE, VIRGINIA QUANTICO NAT'L CEME. 11/18/2011 J. B. JENKINS FUNERAL HOME, INC. Signature of Fureral Servic Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 23a. Part 1. Enter the disease, of complications shock, or heart failure. List only one cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between on each line Immediate Cause (Final Onset and Death Physician disease or condition VO j. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 ☐ No Yes 2 W within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical a B 26. Place of Death (Check only one) examiner? 10 Hospital Other: 1 Impatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Matural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Estrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thui was 10 BUUD 31 31. Date filed (Month, Day, 32. Registrar's Signatu Registrar NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State Amend Item	State of Ma 25 per me	ryland / Dep ,g921,11/(artment 19.42011 Hificate	of Health dhbeath	and Me	ntal Hygid Re	ene g. No. 2	36079
	Physicia	ın/	1. Decedent's Name (First, Middle, La.		doman				. Date of Death Month	5000	3. Time of Death
Auto	Medic Examin		4a. Facility Name (if not institution, give	e street and number)	4613011	4b City, To	wn, or Location	n of Death		4c./County of Deat	
	Funeral		5. Social Security Number 6. S		(In yrs-last birthday)	If Under 1 Months	Year If Und	er 24 Hrs. 8.	. Date of Birth	9. Bir	thplace (State or Foreign
	Director ≥		213 70 0865 1 Usual Residence of Decedent	□ M 2 F	<i>59</i> Yrs.	Imerians		1//	Month, Day	1956	7710
	aryland a-f sho fied at	Director	10a. State 10b. County		10c. City, Town or Li						10d. Inside City Limits 1 Yes 2 No
	n the Ma a or 28 be noti		10e. Street and Number	CL	ul	10f. Zip C				Og. Citizen of What Co	ountry?
	eath wit tems 23 er must	Funeral	1203 E. 354h 11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Deceder	nt of Hispanic (Origin? (Specify	y Yes or No-	14. Race - Ame	
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. ifem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	۵	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No		Cuban, Mexic		an, etc.)	Black, White Specify: Black	/-
21215-0036	n 72 hou e. an "natu Medical	Completed	15. Decedent's Elementary/Seconds/ (0-12)		(Give	edent's Usual kind of work OO NOT use n	done during me etired)			6b. Kind of Business	Industry
	ed withii Hygiene other th	Be Co	17. Father's Name (First, Middle, Last)		Nurs	ing 1-	18. MO		First, Middle, Ma	VU/SING T aiden Surname)	10me
Maryland	Ild be fill Mental narked c	횬	John Crosby St	2.			ma	attie E	3. Boy	d	
	d 2 shou alth and 27 is m		19a. Informant's Name/Relationship (and 196. Mai	ing Address (S		nber or Rural R	oute Number, C Himore	City or Town, State, Zi	ip Code) 2/8
Baltimore,	ge 1 and nt of Hear :: If item or othe		20a. Method of Disposition 1 Durial 2 Cremation 3		20b. Place of Disp cemetery, cre	matory or oth	er place)	Dat	11 /	20c. Location - City of	
altin	permit. Page 1 a Department of t Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Spec 21. Signatur / Funeral Service Lo		Iriero C	Permuto 22. Name and	Address of Fac	10-11-	// IC	atorsville,	MD 21229
<u> </u>	9 9 E E 9		23a. Part 1 Enver the disease, or con	pplications that caused	the death. Do not en	ter the mode	March of dying, such	Funeva i as cardiac or re			Approximate
	Ph _{sician} /	1	shock, of heart failure. List only Immediate Lause (Final disease or condition	one cause on each line	atic Ci	irrhos					Interval Between Onset and Death O MONTH S
	Medical Examiner		resulting in death)	Due to (or all a	consequence of):	morri	hane			/	24 hours
	ed sit	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (o. as a	голзециеное оп.				11 /	1//	
	e be executed ysician and e burial-transit	I Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):			L DORC	MED BY WEDICE	EXAMINER	
1260	icate be g physic is the bu	l edical		d		_	CERTIF	CATION AFF		1	
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of Live Birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pr	egnancy c <i>ify)</i>			23d. Date of do	elivery Day Year
0.	that the ned by the e detach	oy Phy	9·☐ Unknown Part II. Other significant conditions		ut not resulting in the	underlying ca	use given in Pa	art I.	23e. Did tob	6.7	o the cause of death?
to ME	requires been sig	Completed by		<u> </u>					1 \(\sum \) Ye 24a. Was an	24b. Were a	Probably 4 Unknown utopsy findings available
Reco	The law ate has page 2 s	Somp							autops perforn 1 Yes 2	y prior to ned? death?	completion of cause of
ita Çi	sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:	2	ent 3 🗆 DO	Othors	Death (Check o		nce 6 🗆 Other (Spe	oifu)
TT	ling Phy n. After this funeral d	ate: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injui (Month, Day	ry 28b. Time	of 28	c. Injury at work?	28		w injury occurred	
#23ap	or Attend fter death lirector: / n by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not determined	be 280 Place of Inju	ıry - At home, farm, s . (Specify)	M treet, factory,			3f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
#2	Hospital 24 hours a Funeral E	Medical ((Check 2 Medical Exam	ysician: To the best of niner: On the basis of e	xamination and/or inve	estigation, in m	v opinion, death	h occurred at th	ne time, date and	d place, and due to the	e cause(s) and manner stated.
,	To the within to the comple	Ž	only one) 3 L Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the		290	licansa numbe	er	2	9d Date signed (Mor	th Day Year)
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)	Park	16 Ca	altima	10/7/ re, Mb	21218
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	10119	TUILU	ny, U	w(111101	0,1110	71010
	Registr	ar	NOV 0 9 201	1 Sina	p. pa	1000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROSEMARIE 12, 2011 ARNOLD NOVEMBER 5:10 A. M Medical 4c. County of Death BALTIMORE 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death GILCHRIST CENTER TOWSON MARYLAND 8. Date of Birth (Month, Day, Year) 3/3/1920 Social Security Number . Age (In vrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign **Funeral** 218-07-4268 **Director** 91 1 M 2 XF Yrs MARYLAND Usual Residence of Decede ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8133 BARKSDALE ROAD 21286 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XIo Specify: If Yes, Give Year or Dates Specify:WHITE Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE ACCOUNTING **EXXON** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) URBAN GUNTNER ROSA EIBNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health MARTHA MILLER/DAUGHTER 3108 TEXAS AVENUE BALTIMORE, 21234 MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 \square Cremation 3 \square Removal from State PARKWOOD CEMETERY 11/14/2011 injury 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MO1139 THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD in rt 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to tor as a consequence on ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 NO Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 Yes 2 No 3 Probably 4 thknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 2 No 1 Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certif 29d. Date signed (Month) Day, Year)

Registrar

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NCHARLES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

KUMAR

31. Date filed (Month, Day, Year)

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ST SUITE 4105 BAITIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10a-f per fh g927 5-29-12 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 10. Physician/ 5:00A M Julia Barlow Albert 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Hyattsville Sacred Heart Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Davs Hours August 17,1917 94 Maryland 212-05-1493 Director Usual Residence of Decedent 28a-f show 10a, State MD 10b. County Prince 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Arlington Arlington Virginia Yes 2 K No Hyattsville George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5805 Queens Chapel Road U.S.A. Funeral 22207 20782-3898 2125 North Brandywine Street death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 4 yr S Manager Phone Company permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other i any injury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0'Neill ဂ္ Margaret Barlow George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Arlington, VA 22207 2125 North Brandywine St. Cecilia M. Barlow - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place New Cathedral 11/12/11 Baltimore, MD 21. Signature of Juneral Service Licer 22. Name and Address of Facility 5305 HArford Rd. BAltimore, MD Farbort 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cerebro Vascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensive Cardiovasular Disease Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Exami Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🄀 No
9 ☐ Unknown Day 5 Other (specify) Month Year Pregnant at time of death by the Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Records, <u>Hyperlipidemia</u> Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 X No death? certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 X No ರಿ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes Certificate: 28d, Describe how injury occurred After 1 X Natural 5 Pending injury 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director, / completed filled in by the f 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cai 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Media Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) November 10, 2011 D051122 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Esmerando O. Juanitez, M.D. 1160 Varnum St. NE #008 Washingtom, DC 20017

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 4 2011

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0^{Day} 20111 Benita Anthony 4:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthdav) **Funeral** New York Days Hours Min. 08^M7th6^D7^y1^Y9ⁿ47 1 □ M 2√2 F 64 055-42-1866 Director Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21217 2417 Eutaw Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetology Self years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Oler Bellamy Galvester Grier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 Ridgecroft Rd., Baltimore, MD 21206 Linda Grier 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1x Burial 2 Cremation 3 Removal from State Baltimore, MD New Cathedral 11/11/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ජීඑප්ප්රීස් මේ පිරිතින Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 MD21217 uno 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami that the death certificate be executed care has been signed by the attending physician and page 2 should be detached for the man that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Year Month Day 4 ☐ Pregnant g ☐ Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No **a**. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. 8 Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify, Hospital 1 ☐ Yes 2 ☐ No ျှ 1 Hipatient 2 -ER/Outpatient 3 DOA this (28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 - Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060100 09-11 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K Abm ED MIND 3 Universon BLVD

Registrar DHMH 17 Rev 7/2009

State

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32. Registra 's Signa

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MD 20903

11-08289 Eugene Ballard

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		Johns Hopkins Hospital	,		altimore				·			
Funeral			ge (In yrs. last t		Under 1 Yea				DD/YYYY) 9. Bir	thplace (State or		
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any		Usual Residence of Decedent 10a, State 10b, County	10c. City, To	wn or Location						10d. Inside City Limits		
		Md	Balt	imore						1 X Yes 2 No		
Maryland 28a-f show d at once.	Director	10e. Street and Number		10	f. Zip Code			10g. Citiz	zen of What Cou	ntry?		
the M		1812 Broadway			2121				USA			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-fabor other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces	?	13. Was De If Yes, s	ecedent of His specify Cubar	spanic Origin n, Mexican, P	? (Specify Yes ouerto Rican, etc.) [White, etc.	ican Indian, Black,		
er dea		1 Yes 2 3 Widowed 4 Divorced If Yes, Give Yeer	2 X No	1 Yes	s 2 X No	specify:			Specify: Bla	ack		
ours aft	<u>ā</u>	15. Decedent's Education (Specify only highest grade co	mpleted) 16	Sa. Decedent's U	Jsual Occupa	tion (Give kin		16b. K	(ind of Business/			
6 172 ho	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	during most o	n Weld		e retired)	P:	rivet			
withir giene.	틹	1 1 17. Father's Name (First, Middle, Last)			_	Name (First, Mid	CO	ontractor en Surname)				
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ID 21215-003 : should be filed within and Mental Hygiene. 77 is marked other th matic event, the Med	P	19a. Informant's Name/Relationship (Type, Print) \$\frac{1}{2}\$		19b. Mailing Ad		et and Numbe	er or Rural Route	Number, Ci	ty or Town, State	e, Zip Code)		
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Baltimore, MD 2 pernit. Pages I and 2 shou Department of Health and I Important: If iten 27 is in injury or other traumatic		1 Burial 2 Cremation 3 Removal from S	tate cren	matory or other p	olace)		1	1	-			
ti. Pag rtment rtant:	ļ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	_ Ard	lent Cr	e and Address	s of Facility	11/14/ (Hai	nover	Maryland FS PA		
Balti permit. Departm Imports injury o		DILLA AWARESTE	7				iver St			md 21213		
Physician	┪	23a. Part I. Enfer the disease, or complications that cause failure. List only one cause on each line.	d the death. Do	o not enter the m	node of dying,	such as care	diac or respirator	y arrest, sho	ock, or heart	Approximate Interval Between Onset and		
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Box 687 e death certifi. the attending	icia	past 12 months?	at time of death	=	(Specify)			_				
, P.O. Box 687 res that the death certifi signed by the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to dea	th but not resu	Iting in the unde	orlying cause	niven in Part	23e. l	Did tobacco	use contribute to	the cause of death?		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. 11 Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.		Fart II. Ottor significant conditions	ti bat not resu	and ig in the dride	in ying occuso	givoiriiri aic		_		bably 4 Unknown		
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Hospit 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of	ny knowledge,	death occurred	at the time, d	late and place	e, and due to the	cause(s) an	nd manner as sta	ted.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of example and manner stated		or investigation,			irred at the time,					
	ž	29b. Signature and title of certifier			29c, Licens	.M.E.			Date signed (Mo ember 6, 20			
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21		30. Name and address of person who completed cause of Laron Locke MD. Assistant Medical Ex			more Stree	et, Baltimo	ore, MD 2122	23				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Рм 3:50 John Wamoth Buttrey November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth g Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🙀 M 2 🗆 F Days Hours 05/09/1920 214-16-9593 North Carolina **Director** 91 Usual Residence of Decedent 28a-f show 10a. State 10b. County artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Pylesville 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21132 2205 Amoss Mill Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Tavern Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Horace Buttrey Bertha Jane Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 Amoss Mill Road, Pylesville, Maryland 21132 mportant; If item 27 Johnnie Rae Barron (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 \mathbf{X} Burial 2 \square Cremation 3 \square Removal from State emetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard 11/15/2011 Baltimore, Maryland 21. Sign une Se e Licensee ^{22. Name and Address of Facility}
Bruzdziński Funeral Home, P.A.
1407 old Fastern Avenue, Essex, Maryland 21221 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immodiate Cause (Final Onset and Death Ph. sician/ disease or condition sulting in death) Medical stive heart failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examir Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Year Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dei tension Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes of Vital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 **X** No Other: 1 Tyes 1 X Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending Division 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be completed filled in by the within 24 hours after deat To the Funeral Director: 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Hospital 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the Gartifying Nurse Pragtioners to the best of my knowledge, de-29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Drive Bel Air, mo 21014 IOV asrin

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Monta

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			For State	ate of Maryland /	· ·		ental Hygie	ene	0.5005				
			Registrar		Certificate of D	eath T		g. No. 2	36085				
	Physicia		1. Decedent's Name (First, Middle, Last)	BADOH			2. Date of Death Month	Day 2011	3. Time of Death				
lane.	Medic Examin		4a. Facility Name (if not institution, give street		4b. City, Town, or	Location of Death	101	4c. County of Deat					
mary and	1		HOLY CROSS	HOSPITAL	SILVE		iNG	MONTO	OMERY				
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birt 2011	hplace (State or Foreign untry)				
	ind show	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Location			_	10d. Inside O'ty Limits				
	Maryla Ba-f s tified	Director	MD MONTGON	LERY SILL	IER SPR	1006			1 Ves 2 No				
	a or 2 be no	Ö	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?				
	th with ms 23 must	Funeral	13918 CASTI			704	77 - V M -	USA					
36	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 M No Yes, Give ar or Dates.	13. Was Decedent of His If Yes, specify Cubar	Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:					
-00	hours natura lical E	lete	15. Decedent's Education	n 16	a. Decedent's Usual Occupa	ation	1	6b. Kind of Business					
21215-0036	nin 72 he. han " e Mec	Completed	(Specify only highest grade con Elementary/Seconday (0-12)	llege (1 - 4 or 5+)	(Give kind of work done d life. DO NOT use retired)	_	ig .	1.11	_				
7	led within Hygiene. other thar ent, the M	Be C	17. Father's Name (First, Middle, Last)	NA	INFAN.	18. Mother's Name	(First Middle Ma	INFA	01				
Maryland	should be filed and Mental Hygran and Mental Hygran is marked other raumatic event.	To	UNK			CHRIS		BADO	14				
ary	should and M is mar aumat		19a. Informant's Name/Relationship (Type, Pri	nt) 19	9b. Mailing Address (Street a								
Σ	ealth am 27 i		HOLY CROSS HO	SPIFAL 1	200 LOSES	GLEN	RD S	am.E.	20910				
Baltimore,	permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		of Disposition (Name of tery, crematory or other place		ate 2	0c. Location - City or	Town, State				
Balt	permit. Departr Import any inj		21. Signature of Fundal State Ward	Baltimore	Street								
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		Onset and Death								
	Examiner		Tesating in death)	Due to (or as a consequence		F10	S CES	_					
١.		ner	Sequentially list conditions, b. — b. — b. — cause. Enter Underlying	Due to (or as a consequence	1000-1	NW OIL	2 662						
	outed nd ransit	Examine	Cause (Disease or iinjury that initiated events c										
09	sate be executed physician and the burial-transit	edical E	resulting in death) Last	Due to (or as a consequence	e of): 								
	tificate ng phy as the	Med	IF FEMALE:										
Box 687	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal dea ☐ Pregnant at time of death ☐ Unknown		у		23d. Date of de Month	livery Day Year				
P.O.	hat the ed by detacl	by Ph	Part II. Other significant conditions contribute	ing to death but not resulting	g in the underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?				
S,	puires en sigr uld be	ed b					1 ☐ Yes	2 No 3 P	robably 4 🗆 Unknown				
Division of Vital Records,	law has	Completed				· 	24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of				
Ta I	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Check							
Ę	Physic this co	မ	1 Yes 2 No Hospit	1 Minpatient 2 LI ER/0		4 LI Nursing Ho		ce 6 Other (Spec	cify)				
O L	ding I th. After funer	cate	1 Matural 5 ☐ Pending	a. Date of injury 28b (Month, Day, Year)	injury work	y at ? Yes 2 □ No	8d. Describe how	injury occurred					
ivisio	I or Attending Physician: after death. Director: After this certific in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,							
	To the Hospital or within 24 hours after To the Funeral Dir completed filled in	Medical	(Check 2 Medical Examiner: Or	To the best of my knowledge the basis of examination and tioner: To the best of my kno	d/or investigation, in my opinic	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.				
	To th within To th comp		29b. Signature and title of certifier		29c. License			d. Date signed (Mont					
	1		X		72	1550	\	0,31,1	. (
				ed cause of death (Item 23a)			4 8%	Dam (a)	S NE 2000				
	Stat	e	31. Date filed (Month, Day, Year)	32. Fugistrar's Signature	K 4808	MOORLA	ND CN	MEJHEDI	141808 am B1				
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State of Maryland / Department of Health and Mental Hygiene 2 []

			1 - For State Registrar	State of Marylan		tificate of De			Reg. No.	1 0000		
	Dharisis	/	Decedent's Name (First, Middle, Last	st)				2. Date of Dea	nth Day Y	3. Time of Death		
	Physicia Medic		EMMANUE		DOH			101	30, 701	1 2029 1		
	Examin	er	4a. Facility Name (if not institution, give	street and number)	.01	4b. City, Town, or L	,	16	4c. County of Death MONTGOMERY			
1	Funeral			ex 7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8 Date of Birt	h g	Dirthplace (State or Foreign		
10	Director		NA	W M 2 □ F	Yrs.	Months Days	Hours Min.	1013	O'2011	Country)		
	ind ihow at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits		
	viaryla Ba-f s tified	rect	STUDM CM	OMERY SIL	NER	SPRIN	ے د			1 ☑ Yes 2 ☐ No		
	a or 2 be no	a D	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh			
	within 72 hours after death with the Maryland glent. then: the Medical Examiner must be notified at the Medical Examiner.	Funeral Director	13918 CAST	12. Was Decedent Ever in U.S		Was Decedent of His		cify Yes or No-	U S	American Indian,		
٥	er dea or ite niner	by Fu	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		f Yes, specify Cuban.	, Mexican, Puerto	Rican, etc.)		Black, White, etc.		
2-003p	urs aftural", ural",		3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 ☑ No	Specify:		Specify:	BLACK		
2	72 hot "nat ledica	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occupat kind of work done du O NOT use retired)	tion uring most of worki	ng	16b. Kind of Business Industry			
7 7	vithin jiene. er than the N		Elementary/Seconday (0-12)	College (1-4 or 5+)	me. D	INFA	TWA		1208	TUR		
aua	filed valued by different,) Be	17. Father's Name (First, Middle, Last)				18. Mother's Name					
<u>S</u>	uld be I Ment narke natic	욘	UNK						M Br			
<u> </u>	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	3	19a. Informant's Name/Relationship (1)	,		ng Address (Street ar				10 20910		
e,	1 and of Hea item		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place		Date		ity or Town, State		
Ē	Page ment c ant; If ury or		1 Burial 2 Cremation 3 4 Donation 5 Other Speci	J Removal from State								
baltimo	permit. Page 1 Department of Important; If i any injury or c	8	21. Similare of Funeral Servic Licen	Way Director					. Baltimo	ore Street		
i			23a. Part 1. Enter the disease, or com	plications that caused the death		altimore, er the mode of dying.			rest,	Approximate Interval Between		
٠.,	Physician/		show, or heart failure. List only of Immediate Cause (Final disease or condition		AMN	PINOL	is			Onset and Death		
	Medical Examiner		resulting in death)	a. CHORIO V	uence of):	,	1.0					
		er	Sequentially list conditions. if any, leading to immediate	b. PREMA Due to (or as a consequ	I CUR	149	18 W	KS-C	orsi.			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events									
	cate be executed physician and the burial-transit	a Ex	resulting in death) Last									
9	physic the bi	Medical		d								
00	certific nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Testania prognancy	,		23d. Date	of delivery		
DOX	death ne atte ed for	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Feta 4 Pregnant at time of c 9 Unknown		Other (specify)			Mont	th Day Year		
5	at the od by tl		Part II. Other significant conditions	contributing to death but not res	ulting in the u	underlying cause give	en in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?		
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ecords,	iw requ	Completed						24a. Was	psv pr	ere autopsy findings available ior to completion of cause of		
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5	g Physer this eral di	e: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time o	f 28c. Injury	at		dence 6 Dother			
	ending sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation	n	injury	M 1 □	Yes 2 □ No					
DIVISION	or Att	Certificate:	3 Suicide 6 Could not lead to determined			eet, factory, office		28f. Location (City or Tox		or Rural Route Number,		
2	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director, Affect his certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phy	sician: To the best of my know	ledge, death	occured at the time,	date and place, ar	nd due to the ca	ause(s) and manner	as stated.		
	he Ho in 24 h he Ful pletec	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	and place, and due ne cause(s) and mar	to the cause(s) and manner stated. iner as stated.							
	To t To t		29b. Signature and title of certifier	(Month, Day, Year)								
			30. Name and address a person who	completed cause of death (Item	23a) (Type		27500		10, 5	1,2011		
			DR RICHBR			MOORLA	M CM	BEAHE	LSDA M	10 20814		
	Star Registra		31. Date filed (Month, Day, Year) NOV 1 4 2	32 legistrar's Signa	tur.	arkel						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36087 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 74 PM Bradford 2011 dward November - 10 Medical 4b. City, Town, or Location of Death 4c. County of Death a. Facility Name (if not institution, give street and number, **Examiner** Baltimore n/a Johns Hookins Date of Birth 9. Birthplace (State or Foreign **Funeral** Months January 10, 1928 049-22-9667 83 Massachusetts **Director** 1 🗶 M 2 🗆 F Usual Residence of Decedent 28a-f show 10d, Inside City Limits 0a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland n/a Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21211 830 W. 40th Street Apt. 611 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian med Forces?

X Yes 2 \(\sum \) No Black, White, etc. 1 ☐ Never Married 2 😾 Married 1 X Yes If Yes, Give þ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 💢 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education 5+ Headmaster Boys Latin event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ္ Carroll Edward Standish Bradford, Sr. Katherine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 830 W. 40th Street Apt. 611 Baltimore, Md. 21211 Mrs. Nancy Bradford (Spouse) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Towson Maryland 11/15/2011 21204 22. Name and Address of Facility 21. Signature of / e / 1 Se Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Phylician rito disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death sate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗹 No 1 Yes 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniurv Natural Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 3 only one 29b. Signature and title of certification 29d. Date signed (Month. Day, Year) KES-DOU November 10 2011

Registrar DHMH 17 Rev 06-2011

State

parks

600 N. Wolfe St Baltimore Maryland 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Saac 31. Date filed (Month, Day, Year,

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36088 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 9, 2011 Physician/ 5:30 Рм Stefanie A. Bergey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 5207 Springlake Way If Under 1 Year If Under 24 Hrs. 9, Birthplace (State or Foreign 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 135-42-8148 1 □ M 2 🗓 F 62 Director 1949 Greece 14. Usual Residence of Decedent a or 28a-f show be notified at 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Y☐ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral **USA** 21212 5207 Springlake Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. þ 1 Never Married 2X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: white 3 Divorced 4 Divorced Completed Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Clinical Child Psychologist Psychology and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Zafiro Papoulios Peter Antonakos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 5207 Springlake Way; Baltimore, MD 21212 <u>Gregory K. Bergey</u> husband 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 11/14/2011 Cub Hill, MD Other (Specify) 4 Donation Demetrios Cem. 1050 York Road Signature of Fu 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Amyotrophic Lateral Sclerosis 8 months disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Factor fally list randition if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) the the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 V No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page 2 1 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural s after death.

I Director; After the in by the funera 28d. Describe how injury occurred injury 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 11 ASSOCIATE PROGESSOR 00042763 21287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE ST BALTIMORE MARGUANO Corsa MEYER 5-119

DHMH 17 Rev 06-2011

State Registrar Andrea

31. Date filed (Month, Day, Year) NOV 1 4 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}0 JOHN LOWELL BENNETT 4:30A November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Edenwald Towson Social Security Numbe 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F 0172571920 Months Hours China 91 **Director** 219-01-3488 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Me Ital Examiner must be notified at 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location Director 1 🗆 Yes 2 📉 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21286 800 Southerly Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 XXMarried Maryland 21215-0036 Yes 2XXNo If Yes, Give Year or Dates 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Benjamin Franklin Bennett Elvira Wallis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Harriet Siegnund Bennett 800 Southerly Road #1513 Towson, Maryland 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2XX Cremation 3 ☐ Removal from State 11/11/2011 GreenMount Crematory Baltimore, Maryland Donation 5 D Other (Specify) 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home Inc nature of Funeral S 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ uso Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consec resulting in death) Last physician Completed by Physician/Medical Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown s been signed by the same should be detached a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform 1 🗌 Yes 2 🗆 No After this certificate 25. Was case referred to redical examiner? **Division of Vital** funeral director. 26. Place of Death (Check only one) Be Hospital 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 27. Manur of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 5 Pending 2 🗌 No 24 hours after death.

Funeral Director: A Accident Investigation the 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сопретес (Ch within 2 3 🔲 only one) 29b. Signature and title of certifie 30. Name and address of

State Registrar 31. Date filed (Month,

NOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 8, 2011 Physician/ 9:05 A M William Backert, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 212 Benmere Road Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 215-18-3420 **Director** 1 X M 2 □ F 89 1922 Maryland 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at Director 1 ☐ Yes 2X No Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 212 Benmere Road 21060 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1▼ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify. Specify: White "natural" 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) Boiler Maker Gas & Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Backert Valentine Mary of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Benmere Road Glen Burnie, MD Mr. John W. Backert, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park : 11/14/2011 Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed BENTYDEMA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural injury 5 Pending 1 Yes 2 No Accident Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/8 201 pleted cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

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32. Registrar's Signature

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808 LANDIMER DRIVE SHITE 128

GLENBHANIE MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician November Ward 2011 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1.28 M 2 □ F 3,1944 Director 21842830' Aug Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County show at 1 XYes 2 ☐ No or 28a-f st notified a Director MI 10g. Citizen of What Country? 10e. Street and Number * 23a 0. 1034 21206 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Never Married 2 ☐ Married Yes 2 No Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify. þ Specify: 3 Widowed 4 Divorced White "natural" Completed er than "natur, the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) onstruction 7 is marked other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition nephew 1102 Rose Baltimore, Mary and Mi Date UNK 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Allantoun 4 Donation 5 ☐ Other (Specify) La oner Mervice Licensee 21. Signature 22. Name and Address of Encility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Michalley Dr. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final dise se or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Vear in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No Division of Vital Records, P.O. 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1
Inpatient Other: 2 ☐ ER/Outpatient 3 ☐ DOA 2 □ No 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) မ this 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 Thomicide City or Town, State) To the Hospital I Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 24 To the F 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Ohammad 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 1 4 2011

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Basilio :-25 AM ebecca Vovembero Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** IMOVE Balt arbor 05 Pital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number Country) MD Funeral Days Months Hours 1 - M 2 X F 1072171955 56 215-64-4410 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Anne Arundel Brooklyn Park MD 1 Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 USA Funeral 624 Lorca Ave. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 24 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 XNo Specify. White 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Manager and Mental Hygie is marked other Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisy Amelia Lilly John Joseph Windensheim permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 582 Terrace View Ave., Be-Brooklyn Park, MD 21225 Maynard W. Widensheim /Brother Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Arundel Crematory
11/12/2011 injury or Odenton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Pailey Funeral Home and Cremation Service, 4023 Annapolis Rd., Halethorpe, MD 21227 Zi. MOITS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Se disease or condition Medical resulting in death) Examiner Lown Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 1 Yes 2 2 9 Unknown detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🔀 No Yes 2 X N funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ၉ 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 2 🗌 No Investigation Accident completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. .Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Street. Honover 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10,2011 12:30P.M Cristina Almojuela Burce November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County 715 E. Seminary Avenue Towson Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F Months Hours Yrs 92 July 24, 1919 **Director** 216-78-7096 Philippines Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 United States 715 E. Seminary Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Filipino "natural", 3 Nidowed 4 Divorced Completed al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary School Teacher Education 12 04 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Department of Health and Ment, Important: If item 27 is marked any injury or any Felipe Almojuela Maria Vera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $(U_{ullet}S_{ullet}A_{ullet})$ Perry Hall, Maryland 21236 9506 Hickoryhurst Drive Mrs. Nieva Loria (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Tabaco City, Philippines Santuario De Albay 4 ☐ Donation 5 ☐ Other (Specify) unk. Jeffrey L.Gair, Sr. O. Sp. 2. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21(193–2215 (U.S.A.) M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Que to (or 🖠 Examiner 10 years 0 Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 the SB IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the at d be detached for Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No Completed peen Were autopsy findings available prior to completion of cause of death? 24b. 24a. Was an autopsy performę certificate has page 2 1 ☐ Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending work? 2 🗌 No Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one)

DHMH 17 Rev 7/2009

State Registrar

29b. Signature and title of certifier

30-Name and address of persor w

31. Date filed (Month, Day)

Magno

completed cause of death (Item 23a) (Type, Print)

MO

32 Registrar's Signature

homas

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 1^{Day}, 2017 1:11 A. Michael Francis Bognanni Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Abingdon Harford 311 G. Laurel Woods Drive 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours July 18, 1**X** M 2 □ Months Year 1932 Maryland 79 218-28-6345 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location Director ms 23a or 28a-f s must be notified 1 Yes 2 YNO Maryland Harford Abingdon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21009 311 G. Laurel Woods Drive 12. Was Decedent Ever in U.S. Armed Forces? 1952-15 Yes 2 No 1954 If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Examiner Black, White, et 1 Never Married 2 Married Completed by White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Armco Steel Office Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Mandello Michael John Bognanni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 311 G. Laurel Woods Drive Abingdon, Maryland 21009 Benicia F. Bognanni / Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Nov. Date 15, any injury or conce. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entonoment cemetery, crematory or other place) Bel Air Mem. Gardens Bel Air, Maryland 2011 21. Signature f Funeral Service Licensee Evans Funeral Chapel & Cremation Services-BelAir Forest Hill, Maryland 21050 3 Newport Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 g Unknown certificate has been signed by the inector, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 🗌 Yes 2 🗌 No Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home 5 Residence 6 \(\to\) Other (Specify, 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director; / 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar

within 2

(Check

only one)

Signature and title of certifier

filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 13. Physician/ 2011 2:33am M Grayson В. F1eming Clarke Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carro11 Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) Oct. 31. 1 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. Director 916 MD 220-07-0047 95 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 No MD Carrol1 Sykesville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 7200 Third Avenue A - 10821784 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) ပ္ Brandenburg Lula Lauterback permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 6222 Sykesville Road, Sykesville, MD 21784 Mr. Gilbert L. Fleming Jr 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brandenburg UMC Cem. ! 11/16/2011 Berrett, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses Man ttais MOO764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 both motive 10005 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to for selective advance of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗆 No 3 Probably 4 ☐ Unknown Completed this certificate has t een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 1 🗌 Yes 2 - No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29c. License number ND 34849

State Registrar

DHMH 17 Rev 7/2009

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jan

31. Date filed (Month, Day, Year)

11-08176 Alethea Converso

Amend Item 7 per DVR G921 11/22/11 dk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

lethea Convers		1- For State	ate of Maryl	•	artment			Menta	al Hyg		Den No	21	0 1		3609
Physicia	_	Registrar 1. Decedent's Name (First, Middle)	le,Last)		-					. Date of De			3.	Time o	f Death
Medical Exami		Alethea Conv	erso						- 1	Month October	31, 20	Year		2057	hrs
)		4a. Facility Name (if not institution	on, give street and n	iumber)				ocation of	Death			c. County of			
		3121 Steamers Run				Camb	ridge				- 1	Dorcheste			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	If Under		8. Date of B	Birth(MM	1952	BirthpForeign	lace (St	ate or
Director		220-58-2168	1 M 2 X F	59	58	Yrs. Month:	Days	Hours	Min.	Sept	9,-	1953	Count	''Mar	yland
		Usual Residence of Decedent		1											
'any		10a. State 10b. County		10c. City	y, Town or Lo										de City Limits
and show	5	MD Dorch	nester		Cambr	ridge							1	Ye	es 2 X No
Maryland 28a-f show 1 at once,	Director	10e. Street and Number				10f. Zip					10g. Cit	izen of Wha	t Country	? ?	
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	ᡖ	3121 Steamer	Run Road				2161	13				USA			
with ms 23 be no	unera	11. Marital Status		ecedent Ever in I		Was Decede					No-	14. Race - White,		n Indian	, Black,
death r iter nust	n						If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					vville,	ille, etc.		
after nl", o	by F	3 Widowed 4 Div	orced If Yes, Give Ye	ear				No specify:				Specify:		ite	
ours rami		15. Decedent's Education (Spe					al Occupation (Give kind of work done vorking life. DO NOT use retired) 16b. Kind of Business/Industry			ustry					
7	lete	Elementary/Secondary (0-12)	College	(1-4 or 5+)	33,1119	,				/					
5-0036 led within 72 Hygiene. other than "	Completed	12	0		acc	ount 1						Rent .	A Ce	ntei	-
F 5 F 6		17. Father's Name (First, Middle	, Last)				1:	8. Mother's	Name (Name (First, Middle, Maiden Surname)					
21215-0036 hould be filed within 7 ad Mental Hygiene. is marked other than tic event, the Media	Be	Pompeo Les 1 ie Converso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, or Rural Route Numbe								or City or Town State Zin Code)					
imore, MD 2121 Pages I and 2 should be fit nent of Health and Mental isot: If item 27 is marked or other traumatic event,	P										, State, Z	ip Code	,		
ore, MD 2 ies 1 and 2 shou of Health and If item 27 is no ther traumatic		Christa Baum/daughter 388 Shiloh Drive M 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,						Mari	Marion, AR 72364 Date 20c. Location - City or Town, State					ite	
S la of He If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)													
Page Page nent o		4 Donation 5 X Other S	pecify: in st	ate											
Baltimore, permit. Pages lar Department of Hec Important: If its injury or other tr		21. Signature of Function State	Sicen	Directo	r Š	LName and	Mare	of FaciliBo	oard	655 T	и. В	altimo	ore S	Stre	et
E. E. G. B. CE		mm	Mel		В	altimo	re,		2120						
Physician		23a. Part I. Enter the disease, of faiture. List only one cause		caused the deat	th. Do not ente	er the mode of	of dying, s	such as car	rdiac or	respiratory a	arrest, sh	nock, or hea	rt		imate Interval en Onset and
/Medical Examiner		Immediate Cause (Final disease	a. Atheroscle	erotic Cardio	vascular E	Disease									Death
		or condition resulting in death)	Due to (or as	a consequence	of):										
	-	Sequentially list conditions, if any, leading to immediate	b. Due to /er es	a consequence	of).								-		
	Examiner	Chisease or injury that initiated C.													
=	xan	events resulting in death) Last Due to (or as a consequence of):													
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760 cate t	/We	IF FEMALE: 23b. Was decedent pregnant in t	ha	, outcome of pre	egnancy			7			2	3d. Date of			
Box 6876(death certificate the attending physical for use as the b	ian/M	past 12 months?	I I LIVE	birth gnant at time of	2	Fetal death	3 [Ectopic	pregnan	су	Ų	Month	Da	У	Year
eath c	/sici	1 Yes 2 ✔ No 9 Un	deat		5	Other (Spe	city)								
ш ; ері	Physic	Part II. Other significant condit			resulting in th	ne underlying	cause gi	ven in Par	t I.	23e. Did	tobacc	o use contril	oute to th	e cause	of death?
P.O. ires that the signed by the detached	δ									1 🗆 🕻	res 2[No 3	Probal	bly 4	✓ Unknown
ords, w require us been si should b	Completed					-				24a. Wa	as an				lings available
Division of Vital Records, tal or Attending Physician: The law requiring after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be a support of the funeral director, page 2 should be a support of the funeral director, page 2 should be a support of the funeral director, page 2 should be a support of the funeral director.	ם										topsy rform <u>ed</u> ?		rior to coi eath?	mpletior	n of cause of
Vital Rec ysician: The his certificate director, page	ပ္ပြ										s 2 🗸	No 1	Yes		2 No
n of Vital Reding Physician: The Dr. After this certificate funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:				17	of Death (al		
of Vil ing Physic After this uneral dir	P	1 ✓ Yes 2 No	1 1	Inpatient 2	ER/Outpati		•,,					dence 6		Scene	
n of ding Ph		27. Manner of Death 1 ✓ Natural 5 □ Rea	(Mon	te of Injury hth, Day,Year)	28b. Time	of Injury		y at Work?	- 1	28d. Descrit	oe now ir	njury occurre	ea		
tend feath. tor:	atic		ding estigation				-	es 2	_						
ViS or Ar offer of Direction by	ific	3 Suicide 6 Cou	ld not be 28e. Pla	ace of Injury - At	home, farm, s	street, factory	, office bu	uilding, etc			n (Street n, State)	and Numbe	er or Rura	i Route	Number, City
DIVI: the Hospital or A hin 24 hours after the Funeral Dire	Certification:	4 Homicide	ermined (Specif)	y)											
E Hos 24 h Fun etely			hysician: To the b												-,
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical		aminer: On the basis and manner		and/or invest				urred at	tne time, da					
e s e s	×	29b. Signature and title of certific	er	\		29		License number 29d. Date signed (Month, Day, Year)							
		1 // 14	Leant				O.C.N	Λ.E.			No	vember	2, 2011	1	
N		30. Name and address of person													
1.		Laron Locke MD. A	Assistant Medic	cal Examiner	900 W.	Baltimore	Street	, Baltim	ore, M	ID 21223					
S	tate	31. Date-filed (Month, Day, Year)	32.1	Registrar's Signa	ure	1 0									
Regis	_	ALLEY I / 7/1177	Married.	a. 1	arke										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month 0340 A M Physician /Medical November 201 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 68 219-40-7773 09/194 MARYLAND **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number U.S.A. BIDDLE 2200 E death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 🗌 Yes à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOME MAKER IFE 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bullock JAMES OSCAR ADA ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GRAND P.O. BOX 7183, BALTIMORE, MARYLAND 21218 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State LANSdOWNE, MARY IAND 12011 22. Name and Address of Facility the DERRICK C. JONES FIH, D.A. 21. Signature of Funeral Service Licenses BALTIMORE, MARYTAND AUE. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Ap oximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or shock, or heart failure. List one cause on each line Immediate Cause (Final **Physician** ung cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760. Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 5 Other (specify) been signed by the at should be detached Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 Yes Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 🗌 No 1 Yes 2 X No I or Attending Physician: The after death.

Director: After this certificate completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \subseteq Yes 2 \infty No Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1X Natural 1 Tes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Michael R. g MD Res - 000 November 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Michael R.

31. Date filed (Month

Grunwald

4 2011

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0325A M **Physician** 2011 NOV hadious 11 ha pman homas /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Bultimore Cery Date of Birth (Month, Day, Year) 7-35-1940 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 № M 2 🗆 F 218-34-169 8 Usual Residence of Decedent Director 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the Mydical Examinat must be notified at 1 Yes 2 No timore **Funeral Director** mn 10g. Citizen of What Country? 10e. Street and Numb 320 21214 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 ♥No land 21215-0036 Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) be filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) aborer Genera 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important; If Item 27 is marked ot any injury or other traumatic even once. Mental pman narles nomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Street 3320 resstman Chapman, timore, 20a. Method of Disposition Pages 1 3 ☐ Removal from State 1 ☑ Burial 2 ☐ Cremation lowson mo 4 ☐ Donation 5 ☐ Other (Specify) Greene Funeral Services 22. Name and Address of Facility 21. Signature of Funeral Service Licer Kandallstown me 21133 Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Associated with Chronic Renof /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): P,O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) s been signed by the s should be detached to 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by pertension 2 No 3 Probably 4 Unknown 1 ☐ Yes Diabetes Mellitur 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? 2 - No 1 □ Yes Division of Vital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending t hours after death. uneral Director: Aft ely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ausent L. PEULUS, MD SINAI EN/UES, Bu HOSPITAL OF NO 31. Date filed (Month, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CRUSOE NOVEMBER 2011 10:15 PM NORMA L. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birtl **Funeral** Davs Hours Min 1 ☐ M 2🛣 F MAY 19 1929 MARYLAND Director 82 579-36-0044 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 □ No PRINCE GEORGE'S LANDOVER HILLS MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 20784 USA 3806 THORNWOOD ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 11th HOUSEKEEPER of the and Mental Hygie 27 is marked other traumatic event, the permit. Page 1 and 2 should be filed 1 Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ STATESMAN-MILLS ARTHUR HOLMES VICTORIA 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3806 THORNWOOD ROAD LANDOVER HILLS, MARYLAND CRUSOE /DGT VANESSA R. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place MD VETERANS CEMETERY 11/14/2011 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. . Signature of Funeral_Service Licenses Kelne 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. 23a. Part 1. Enter the dise shock, or heart failur Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) weer in Examiner deusitus ectron due Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-transit attending physician and Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy this certificate has page 2 Yes 2X No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 Yes 2 K No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural injury 5 Pending 1 Yes 2 🗆 No Accident Investigation completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO NOVEMBER 10, 2011 D53709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CHAWLA M.D., 14300 GALLANT

32. Registra s Signa

FOX LANE SUITE #210 BOWIE, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH,G921,11/17/2011,WS
State of Maryland / Department of Health and Mental Hygiene 36100 1 - State Registrar Reg. No. 2 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death NOVEMBER Day 2 2011 Physician/ 2:15P M CUNNINGHAM HENRIETTA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S 12705 WILLOW CREEK COURT BOWIE Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 219-48-7258 Months Days Hours (Month, Day, Year) MAY 1 1947 Maryland 1 🗆 M 2 🔀 F 64 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ¥ Yes 2 □ No PRINCE GEORGE'S BOWIE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20720 12705 WILLOW CREEK COURT 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 👿 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT HUMAN RESOURCE other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental P ပ Lucille permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Thomas Brown Spriaas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andre Cunningham / 12705 Willow Creek Ct. Bowie, MD 20720 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 🙀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, Lincon Cemetery 11/10/11 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee Naphney . Cornel 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ 10 a Metastatic Breast Cancer years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 X 9 ☐ Unknown detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it **Division of Vital** the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{XResidence} \) 6 \(\text{Other} \) Other (Specify) 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26250 NOVEMBER 3. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1221 MERCANTILE LANE LARGO, MARYLAND 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ack

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Novembe Physician/ :05 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death unty of Death Idor ntinaton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Min **Director** re bruary 28a-f shov with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Mar<u>ylana</u> 1 Yes 2 No ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral or items 23a 10602 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. 'natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) INOVA other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Page 1 and 2 should be ment of Health and Menta Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Department of Health Important: If item 27 phas. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility Chinn Signature of Funeral Service Licensee Service Shirlington Read Artington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of). if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No page 2 should be detached for Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn hours after death. **Ineral Director:** After this certificate Yes To Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Other 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 🗌 Yes 2 \square No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

Date filed (Mo.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First_Middle, Last) 2. Date of Death Physician/ 20:00 M 2011 MOINC november Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Himore Shins Hopkins 8. Date of Birth 9. Birthplace (State or Foreign ge (In yrs. last birthdav) **Funeral** 217-09-8081 Country) Hours Min (Month, Day, Yea 09-26-1913 98 Maryland **Director** 1 🗆 M 2 💆 F 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director Baltimore N/A 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 Funeral 4409 Kavon Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ò þ 1 Never Married 2 Married Should be filed within 72 hours with and Mental Hygiene.
27 is marked other than "natural", o Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired)
Sales Elementary/Secondary (0-12) College (1-4 or 5+) Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernestine Schwichtenberg Bertha John Muller other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1125 C Rayville Road Parkton, Maryland 21120 Department of Health an Important: If item 27 is n 1125 C Rayville Road Mr. Carlos Olaguer - Grandson 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date emetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Baltimore, Maryland 11-14-2011 Baltimore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road 22. Name and Address of Facility 21. Signaty Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enject the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ troke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buris Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No 9 Unknown Month Pregnant at time of death signed by the at d be detached for Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has death?
1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify, after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral E

completely filled the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mp/Kins

32. Registra 's Signature

31. Date filed (Month, Day, Year)

NOV 1 4 2011

00C

600 North Wolfe St. Bautimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Melvin Cougle November 10, 2011 7:30 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ac. County of Death

Baltimore County 202 Duke of York Lane Cockeysville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours 215-34-5099 1, Day, Year) 13, 1937 **Director** 74 Texas, Maryland Usual Residence of Decedent f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 🗌 Yes 2 🄀 No 28a-Baltimore County Cockeysville Maryland 10e. Street and Number ö 10g. Citizen of What Country? Funeral 23a United States 21030 202 Duke of York Lane filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, an "natural", or ite Medical Examiner Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Welder N/A LaFarge 80 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ should be William Cougle Dorothy M. Bosley and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 i Felton, PA. Mr.William Charles Cougle (Son) 9933 Park View Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
(Baltimore County) Monday permit. Page 1
Department of Important: If it Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Popular Grove Meth.Ch.Cem. Nov. 14, 2011 Phoenix, Maryland Signature of Funeral Service Licensee Jeffrey I. Cair, Sr. CFP 2 Name and Address of Facilities Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner**) (abetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or) attending physician and for use as the burial-transit 021 Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has le 2 autopsy page ; performed? this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State Registrar Janie

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

York rd. Lutherville.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Concetta Costa 2011 4:00 P M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7405 Glenoak Avenue Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, March 09, Months Hours 69 212-40-8290 **Director** Baltimore, Marylan Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director Maryland Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 "natural", or items 23a or edical Examiner must be Funeral with 7405 Glenoak Avenue 21234 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Philip Joseph Costa, Sr. Sarah Rose Messina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7405 Glenoak Avenue Baltimore, Maryland 21234 Philip Joseph Costa, Jr. (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date November 12, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery Baltimore, Maryland 2011 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) day Medical COPD Due to (or as a consequence of) Examiner Cas Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed the burial-trans Pertension and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical tas Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) ed by the a g 🗍 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Peatl 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The section of the cases of the section of the sect (Check To the 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) angoria

State Registrar 2314

arko

JOPPA

M.D

Registrar's Signature

MD

SUITE 1

21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BANGORIA

Day, Year)

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Funeral Director		5. Social Security Number	6. Sex	7. Age (1	In yrs. last birth 45	iday) Yrs.	Months	Mantha Dava Moura Min					8/1966 Maryland		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygicine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Joyce L. Caudi	11 (moth	er)	Tagin at					Road	Elki Date	ton	MD 2	192	Town, State
Ore, geslan of Hea in frien		20a. Method of Disposition 1 Burial 2 Crematio	n 3 Removal	from State	· I	ory or oth	her place)		.		10/11	- 1		-	ter, PA
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S	Specify: a Ligensee		R.A.Fe		Name and A								
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Sox (death ce attend	Physician/Medic	1 Yes 2 No 9 Ur	alcaeura	gnant at tir known	ne of death 5	Ot	ther (Spec	ify)				- 1			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	by Ph	Part II. Other significant condi	itions contributing	to death b	out not resulting	g in the (underlying	cause gi	iven in Par	rt I.		d tobac			the cause of death? bably 4 Unknown
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To the Ho within 24 To the Fu	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
F.3 F. 8	Me	29b. Signature and title of certifier						29c. License number 29d. Date signed O.C.M.E. November 7,							
		30. Name and address of person	on who completed o	ause of de	ath (Item 23a)			J.U.I	vI. L.						
		Carol Allan, MD A	ssistant Medic	al Exam	iner 900 \	W. Ba	ltimpre \$	Street,	Baltimo	ore, MD	21223				
	oto	31. Date filed (Month, Day, Year) 32. Registrar's Signature													

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per dr., g921, 11, 14, 2011 dhb eath 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Comeans Physician/ Month 3:00 Рм ola 06.2011 Medical November 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 517 Lochaber Court Glen Burnie 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. **Funeral** Security Number Hours Min 1 - M 2 1 F Month Director 220-01-1923 100 07/25/1911 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Glen Burnie Maryland Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 1517 Lochaber Court 21061 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 12 **BGE** <u>Maintenance Department</u> Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic injury or other traumatic John Reheard Mary Elizabeth Urey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linthicum, Maryland 21090 Velma G. Dill/ Daughter 441 Shipley Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation S Other (Specify) Brooklyn Park, Maryland Hill Cemetery 11/15/2011 21. Sign 22. Name and Address of Facility Kirkley-Ruddick Funeral Home Immediate Cause (Final Onset and Death Physician/ Previuonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Fibrillation Amou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). netension and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical disease Coronary ante P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Division of Vital Records, MOJ4 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performe this certificate 1 Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completed filled in by the fι ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a)

Registrar

State

31. Date filed (Month, Day,

Year

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9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	li li	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	cify Yes or No- Rican, etc.) 14. Race - American Indi Black, White, etc. Specify: White				
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Balt	permit Depart Impor any in	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & C P.O. Box 195 Sykesville, MD 21784											
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	n 24 hou n 24 hou le Fune	Medical	(Check 2 L Medical Exam	rsician: To the best of m liner: On the basis of exa se Practioner: To the be	mination and/or investi-	gation, in my opinio	on, death occurred :	at the time date an	d place, and due	to the cause(s) and manner stat	ted.		
	To th		29b. Signature and title of certifier			29c. License	number		9d. Date signed	(Month, Day, Year)			
	,0	-	30. Name and address of person who	completed cause of dea			1660		11/6/2	-011			
	10		THOMAS K.	CALVIN TI	MO 241	STORENZ	Avenue	L-CS MIN	うてもと	MACILLE 2417			
	Stat Registra		NOV 1 4 201	32. Registrar's	s Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 Day Lois DeJuliis 12:30 AM 2019r Physician/ N & Onth Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Cecil **Examiner** 505 East Craighill Channel Drive Perrvville 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Months 213-32-8425 1 🗆 M 2 🗶 F Hours Min Feb. Day 3 1935 Mary Tand 76 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Directo Maryland Baltimore White Marsh 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 21162 U.S.A. 5817 Pine Hill Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. ρ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James L. Jovce Henrietta Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike DeJuliis / Son 202 Havnes Court Abingdon, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 a permit. Page 1 and Department of H 1 Burial 2 K Cremation 3 Removal from State Hi Intop Service Corp. 11/11/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or combications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial-Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atter for u in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death the a Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law certificate has the irector, page 2 s Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specific Process) examiner? 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, year occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MIDof death (Item 23a) (Type, Print) Name and address of person who completed cause Havrede Grace, MD 21078 jamin Lee Revolution Mud (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^y4 November 2011 5:00 A M Robert W. Driber Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Presbyterian Home of Maryland Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 157-16-6983 Director 1 X M 2 🗆 F 83 July 14, 1928 New Jersey Usual Residence of Deceden show 10c. City, Town or Location 10a, State with the Maryland notified at Director 28a-f 1 Yes 2 X No MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21286 1210 Stevenson Lane USA ural", or items ! death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. iant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiuny or other traumatic event, the Medical Examiuns White Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Priniting 0wner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Margaret Malloy Driber Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Stevenson Ln. Towson, MD. 21286 Heidi Amaral/ Daughter Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 11-18-11 Yardley, PA. 4 Donation, 5 Other (Specify) Ignatius Cem. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ontir disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death signed by the ald be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)
Nove Ser 14, 2011 29b. Signature and title of sertifier 29c. License number 힏 037016 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth M. Green, mo 6701 N. (Links St., Sh.) Lite 4104 Biltnon, mb 21204

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 4 2011

32. Registra Signat

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Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	230	o. If yes, ou 1 Live 4 Preg 9 Unk	Birth 2 gnant at ti	Feta	death 3		c pregnand (specify)	Э у			_		Date of Month	delive	ery Day	Year	
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Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		4 Homicide	determin		<u>b</u> uild	e of Injury ing, etc. (i	- At ho Specify,	me, farm, stre	eet, facto	ory, office			28f. Location City or Quart	n (Stree: Town, S: ers	t and Nu tate) 6 Rd • •	Bow	Bow Ley	Route Nur. Lexs S Qua	rters,	MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Warren Lee Diver November 11 9:55 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice **Baltimore** If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ocial Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 220-24-7320 **Director** 1 № M 2 🗆 F 84 December 21. 1920 Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland N/A Baltimore 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2508 Ailsa Avenue 21214 LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Was Deceuent 2 Armed Forces? 1 M Yes 2 No WWII 1 X Never Married 2 Married by 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White VOVEMBER 11, 2011 Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 n and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Johns Hopkins Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harrison Morton Diver, Sr. Mary Wickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. George Diver/Nephew 5817 Meadowood Road Baltimore Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Oaklawn Cemetery 11/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland 5305 Harford Road 22. Name and Address of Facility e of Funeral Service Licenses Leonard J. Ruck, Inc. Baltimore Maryland 21214 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? page 2 should be detached for Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe Il or Attending Physician: The after death.

Director: After this certificate h funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be Other: 1 Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 5 Pending Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and who completed cause of death (Item 23a) (Type, Print) 2300 DUL

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ÎÒ. 2011 November Alnetia Ewing 9.53 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>College Manor</u> Lutherville Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 220-20-5891 **Director** 1 □ M 2 X F 98 Usual Residence of Deced Nov. 17,1912 Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 🗆 Yes 2 🗓 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 E. Joppa Road, 21286 U.S.A. Apt. 1006 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Ewing Clara Knight George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Roberts 27297 William Street Road Millsboro, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jessup Meth. Cemetery Sparks Maryland . Sign in conf Fune 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 ia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?

1 Yes 2 X No signed by the at td be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 INO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 2 No 1 Yes 1 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al filled in by the 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month, Dav. Year)

NOV

4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 ear Sheila Etowski-Javed November 4:30 AM M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Devlin Manor Nursing Home Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 27, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F **Director** 1950 Maryland 219-58-1807 60 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at t of Health and Mental Hygiene.
If item 27 is marked other than "natural" 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21550 400 Glade Square #22 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, δ 1 Never Married 2 Married ☐ Yes 2 X No 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ 12 teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Joseph Etowski Helen Maxine Loughrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Carole Holt/friend 1245 King Wildesen Road Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Wade State Anatomy Board 655 W. Baltimore Street MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Tyes 2 - No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Aipleted filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3. 2011 00017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lavale MO 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:03 PM Elder November Margaret 10, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Genesis Perring Parkway Center Baltimore 3. Date of Birth (Month, Day, Year) 12/13/1936 9. Birthplace (State or Foreign 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2√□ F 74 MARYLAND Director 213-34-9182 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be multified at 1 ☐ Yes 2 XNo Director MD BALTIMORE NOTTINGHAM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 4102 TAYLOR AVENUE or items 23a APT. 209 21236 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ò Specify: 3 ☐ Widowed 4 💢 Divorced WHITE than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DUTY NURSE HEALTH CARE 12TH GRADE d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ARTHUR O. STENBURG SYLVIA FEINBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Pages 1 and 2 SHARON L. PHIPPS/DAUGHTER 6014 MARYS CIRCLE STEWARTSTOWN, PA 17363 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 🗍 Removal from State METRO CREMATORY, INC. 11/11/11 | CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a Staje IV Glioblastoma Multiforme Immediate Cause (Final Physician October 2011 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) signed by the a d be detached for 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ξ 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 28b. Time of Injury 27. Manney of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 5 ☐ Pending investigation 1 Natural n 24 hours after death.

e Funeral Director; A
letely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide vuse Practitiones 1 • Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Michelle E. Kalender, CRUP R097104 november 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

NOV 1 4 2011

Genesis Perring Parkway Center 1801 Wentworth Road Baltimore, Maryland 21234

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			101	ate of Maryland / Depart			lental Hy	giene		
			State Registrar	Cer	tificate of L	Death		Reg. No.	1 	35115
ı	Physicia Media		Decedent's Name (First, Middle, Last) DEBORAH	EDELMAN			2. Date of Dea Month NOVEME		Year 2011	3. Time of Death 10:40 A M
- Kingling	Examir		4a. Facility Name (if not institution, give street a	nd number)	4b. City, Town, or	r Location of Death		4c. County	of Death	
manage Sell			5734 RIDGEDALE ROAL		BALTI If Under 1 Year				/ A	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	v, Year)	9. Birthpl Counti	ace (State or Foreign y)
			Usual Residence of Decedent	51			10/14/	1960		NY
	yland if sho ed at	ţċ	10a. State 10b. County	10c. City, Town or Lo	cation				10	d. Inside City Limits
	e Mar r 28a- notifi	Director	MD N/A 10e. Street and Number	BALTIN						1 X Yes 2 □ No
	ith th	ral	5734 RIDGEDALE ROAL	`	10f. Zip Code	209		10g. Citizen of W	Vhat Count	ry?
	ems armus	Funeral	11. Marital Status 12. Wa	is Decedent Ever in U.S. 13. V	Nas Decedent of H	ispanic Origin? (Spe	ecify Yes or No-		e - America	n Indian,
9	fter de , or it amine		1 Never Married 2 X Married 1 [Yes 2 X No	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		k, White, e	tc.
Maryland 21215-0036	tural	Completed by	3 U Widowed 4 U Divorced Ye.	ar or Dates.				Specify:		ITE
15	72 hc n "na nedic	lgi	15. Decedent's Education (Specify only highest grade com	pleted) (Give I	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	ing	16b. Kind of Bu	isiness/Ind	ustry
212	within giene. er tha the l		Elementary/Secondary (0-12) Co	lege (1-4 or 5+)	LTER			HEA	LTH	
pu	filed tal Hy d oth event	o Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)	
yla	uld be i Meni narke natic	မ	IRVING	EDELMAN		ROSALIN				SIEGEL
Mai	2 sho th and 27 is r traun		19a. Informant's Name/Relationship (Type, Prin JOSEPH DAVIS/HUSBA)			ALE ROAD				
re,	f Heal item		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Date	20c. Location -		
altimore,	Page Tent o		1 ☑XBurial 2 ☐ Cremation 3 ☒ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State Cemetery, cren MT . ARARA	natory or other place		3/2011	FARMIN	GDALE	. NY
alti	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		. Name and Addre			ISON & B		
Ω	8 2 E 2 9		· ceres	3	8900 REIS	TERSTOWN	ROAD, I	PIKESVIL	LE, M	D 21208
			23a. Part 1. Enter the disease complication shock, or heart failure. List only one caus	s that caused the death. Do not ente e on each line.			, ,	rest,	- 1	Approximate Interval Between Onset and Death
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		ner		Due to (or as a consequence of):						
	cuted nd transit	Examiner	Cause (Disease or injury that initiated events							
	ate be executed obysician and the burial-transit	al E	resulting in death) Last	Due to (or as a consequence of):						
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P.O.	it the o	Phy	9 Unknown Part II. Other significant conditions contributi		ndarking cause si	on in Bort I	00 0:44			and the state of
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ords	require been si should	etec					24a. Was	• • •		sy findings available
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<u> </u>	an: Th tificata tor, pa	Be C	25. Was case referred to medical		26. PI	ace of Death (Checi	1 L Yes	2 X No 1	☐ Yes	2 □ No
Vit.	nysicia lis cer I direc	To B	examiner? 1 Yes 2 No Hospita	: 1 Inpatient 2 ER/Outpatien	l Oth	or		lence 6 🗌 Othe	r (Specify)	
of	from Programmeral		27. Manner of Death 1 Natural 5 Pending	Date of injury (Month, Day, Year) 28b, Time of injury	28c. Injury work	?	28d. Describe h	ow injury occurre	ed	
ion	ttendi death tor: A the f	Certificate:	2 Accident Investigation	Diagram Albania famoralia		Yes 2 ☐ No				
ivi	l or A after Direc	Cer	4 Homicide determined	 Place of Injury - At home, farm, streen building, etc. (Specify) 	еет, тастогу, опісе		28f. Location (S City or Tow	Street and Numbern, State)	r or Hurai i	Houte Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical		o the best of my knowledge, death of						
	To the Ho within 24 To the Fu completel	Med		the basis of examination and/or invest itioner: To the best of my knowledge,						
	To T		29b. Signature and title of certifier		29c. License			29d. Date signed		ay, Year)
			271	~		18350		11(10	11/	
			30. Name and address of person who tomplete	Rolling Cause of death (Item 23a) (Type, P	3:116	1 2093	John	Fin .	1	۵
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	-			(3	
	Registra	ar	NOV 1 4 2011 Cener	~ / //						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland / Depa	artment of H			jiene eg. No.201	36116
П	Physici	an	Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	Day Yea	3. Time of Death
4	/Medic	al	Catherine Evely			45 ON TO	al annian of De	October	26, 2011 4c. County of De	8:00 PM M
*	Examin	er	4a. Facility Name (If not institution, giv Multi Medical (4b. City, Town, o		aatn		
100	Funeral	A	5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year	SON If Under 24 F	Irs. 8. Date of Birth	9.8	imore inthplace (State or Foreign
г	Director		220-20-5341	I□M 2∏F	84 Yrs.	Months Days	Hours M	in. (Month, Day Feb 13	, 1927 Ma	ryland
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary!	tor	MD Baltim	ore	_	owson				1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	1016		10f. Zip Code		1	10g. Citizen of What	Country?
	th with 235.0	al D	212 Aigburth Ro	ad #110			21286		U	SA
	tams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ar Black, Wi	nerica <i>n</i> Indian, nite, etc.
36	or i	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🙀 No	Specify:		Specify: W	hite
21215-0036	72 hours after death with the Maryland natural", or tlams 23s or 28a-1 show Jisal Examinatine Loudilled at		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	ss/Industry
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and	Antal Harrial Harrial Harrian	Be	17. Father's Name (First, Middle, Last					Name (First, Middle,		
Maryland	2 should be and Mental is marked and marked and marked and metic ev	To	Herman Milton El 19a. Informant's Name/Relationship (10h Maili	na Addraca (Stroot	1	n Catherin	ne Baker r, City or Town, State	Zin Code)
<u>⊠</u>	nd 2 saith an 27 is i		Barbara Swenson/					Towson, N		, 2.p 00de)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "natural", or Itams 23s or 28a-1 show any injury or other traumetic event. It Medical Examinating the colling at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special		20b. Place of Dispo cemetery, cres	osition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
Balti	permit. Departm Importe any inju		21. Sign ture of Funeral Service Local	Pelpir		2. Name and Addre tate Anat altimore,	_		Baltimore	Street
	*		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each lir	I the death. Do not ent	er the mode of dyi	ng, such as card	diac or respiratory ari	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- a	Pailure	to the	ive 1			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
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9	artifica ing ph e as th		IF FEMALE:							
O. Box	that the death certificate be executed set by the attending physician and detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖟 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o Month	delivery Day Year
P.O.	Attanding Physician: The law requires that the rideath. r death. actor: After this certificate has been signed by the tuneral director, page 2 should be detache.	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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islo	ttand death stor: / the t	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 200 Place of Init	ry : At home, farm, str		Yes 2 □ No	28f Location (S	treet and Number or	Rural Route Number
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	To tha Hospitel or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical C			of my knowledge, deat f examination and/or in ated.					
	To the within To the Comp	ğ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	onth, Day, Year)
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			30. Name and address of person who				0 -	0		
	-0		31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	MEDICA	LLEN	NEK		
	⊚ Sta Registr	4	or. Date med (Month, Day, Fear)	SZ. Hegisti	B. A	land I				
DH	MH 17 Rev 1/20		NOV 1 4	2017 Dena	in p. of	acces		<u> </u>		Pá

DHMH 17 Rev 1/2001

11-08308 Justin Lee Fogle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 3611 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day November 5, 2011 Madical Examiner 2226 hrs Justin Tee Fogle 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1296 West Patrick Street Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country)Maryland 1 XM 2 F 26 1985 Yrs Jan. 5, 213-08-2140 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 1 X Yes 2 No 28a-f sho should be filed within 72 hours after death with the Maryland and Mental Hygiene. Maryland Woodsboro Frederick Director 10f Zip Code 10g, Citizen of What Country? 10e Street and Number 609 Weinberg Court 21798 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married 1 Yes 2 X No If Yes, Give Yeer or Dates: 1 Yes 2 X No specify: 4 Divorced White \$ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than electrical electrician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Edward W. Fogle Tina Poole 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rtment of Health and Mortant: If item 27 is m. y or other traumatic c Edward W. Fogle/ father 609 Weinberg Ct. Woodsboro. MD 21798 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 11/11/2011 All County Cremation Sykesville, MD Donation 5 Other Specify 21. at e duneral Service License 22. Name and Address of Facility Hartzler Funeral Home ar marine 404 S. Main St. Woodsboro, MD 21798 Tart I. Enter the disease, or complications that ca publishe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** veen Onset and failure. List only one cause on each line /Medical Death a Oxycodone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and an/Medical AMENDED 23a, 27, 28a-f, per me, g921 11-16-11 smX UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Physicia 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed* death? 1 ✔ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital 8 Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 X No unknown 5 Pending Director: d in by the f 11-5-11 fd 10:11 pm 2 Accident Investigation 28e. Place of Injury. At home, farm, street, factory, office build Found: in parked vehicle/(Specify) parking lot 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be hours after or Town, State Dunkin Donuts 1296 West Patrick St. Frederick, MD within 24 hours a 4 Homicide (Specify) parking 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E November 6, 2011 lakery 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 4 201 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🙀 M 2 🗆 F March 3. Months 049-14-6837 90 Director Connecticut Usual Residence of Decedent shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Parkville 28a-f 1 Yes 2 X No 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 8820-4119 Walther Boulevard USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 XYes 2 No WWII Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 💢 No Specify. 3 ₩ Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked 2 Nicholas T. Ficker Mary Dodge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jane McCloskey/ Daughter 489 Cassatt Court West Chester PA 19380 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 11/14/2011 4 Donation 5 Other (Specify) Hilltop Service Corp. Towson, Maryland f Funeral Service License 22 Name and Address of Facility Leonard J. Ruck, Inc <u>305 Harford Roád Baltimore Maryland 21214</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as **Examiner** Securentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) and -trar resulting in death) Last Due to (or as a conseq attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) atural 5 Pending Accident М 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sign ture and title 29d. Date signed (Menth, Day, Year) 8800 State NOV 1 4 201

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05^{ay} 20 fg Betty D. Freeman 6:45p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Manor Care-Ruxton N/A Baltimore If Under 1 Year If Under 24 Hrs. cial Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 214-26-1055 (Month, Day, Year) Director 1 - M 2 XF 06/11/1929 82 Virginia Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d Inside City Limits Director notified MD Baltimore Co. Towson 1 Yes 2 X No 0 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 7000 N. Ruxton Rd. 21204 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. other than "natural", ent, the Medical Exal Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ementary/Secondary (0-12) College (1-4 or 5+) N/A 7th Grade Housewife traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental File is marked or ျှ William Taylor Willie Bell Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Annie Harris(niece) 5304 Harford Rd. B208, Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 11/16/11 Baltimore, MD 21. Signature of Funeral Service Licenses ਤੌਰਾਂਡਵਾਸੀ^{Ad}ਜ਼ਾਲਾ Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 MD21217 Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or pleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Complications Bowel disease or condition resulting in death) OF WECKS Medical Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury Examine Otie to (or as a consequence of) and -tran that initiated events resulting in death) Last Due to (or as a consequence of) physician ar Physician/Medical that the death certificate be P.O. Box 68760 as t IF FEMALE ase 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fracture of humans, devicen Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? fulluc seosis renal 1 Yes 2 No aute Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) miner? 1 Yes Hospital: Other: 2 No ျ 4 Nursing Home 5 Residence 6 Other (Specify) WO 30 (Ce 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred UN K 5 Pending 1 Natural Accident UNKNOWA 1 🗌 Yes I Director: And in by the f Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined NUISING 7001 N. Charles ST Home within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ature and title of certifier 29c. License number ess of person who completed cause of death (Item 23a) (Type, Print) N Charles HARVES AVI 0.101

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day

NOV

1 4 2011

32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jerome Greer, Jr. Laurence 3:00P November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbot 6692 Edge Road Royal Oak 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Year If Under 24 Hrs. **Funeral** 216-38-2888 Hours Min. **Director** 1 **X**M 2 □ F Maryland 7/8/1941 70 or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Talbot Royal Oak 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral U.S.A. 21662 6692 Edge Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ρ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Admin. State Highway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Ethel Bayer Laurence Jerome Greer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
305 D Foxfire Place Cockeysville, MD 21030 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 305 D Foxfire Place Justin K. Greer / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State Owings Mills, Maryland Garrison Forest Vet. 12/5/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 6 Towson, Maryland 21204 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural Accident 5 Pending work?
1 Yes I Director: Af 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Callying Nurse Practitioner T. the Cantering new log of an occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of contifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and add 10 31. Date filed (Month, Day, Year) **NOV 1 4 2011** State Registrar

2

11-08394 Judith Anne Gailey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Judith Anne Gailey 4a. Facility Name (if not institution, give street and number) Carroll Hospital Center 4b. City, Town, or Location of Death Carroll Westminster 4c. County of Death Carroll Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) OK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits	Physici	ailey	1- For State Certificate		lygiene Reg. No. 2. Date of Death	2011 361
Carroll Hospital Center Carroll Hospital			Judith Anne Gailey		Month Day November 8, 2	2011 Year 2018 hrs
440-44-5895 w size p country OK Cleveland Norman Land Norman Land Norman Land L	1		Carroll Hospital Center			· ·
The second of th			440-44-5895 _{1□M 2∑F} 68	Months Days Hours Min.		Poreign OT
The content of the	<u> </u>	rector	10a. State 10b. County 10c. City, Town or Loc OK Cleveland Norman	10f. Zip Code		
Approximate interval between Cross and Examined Control of Cardiovascular Disease or conditions suiting in death) Last	ar death with the I, or items 23a or ar must he notifis	Funeral Dir	11. Marital Status 1 Never Married 2 XX Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
Approximate interval	36 hin 72 hours after e.e. than "natural", edical Examine	npleted by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	edent's Usual Occupation (Give kind of wing most of working life. DO NOT use retire	tired)	b. Kind of Business/Industry
Approximate interval	1215-UU d be filed with Aental Hygien aarked other event, the M	o Be Corr	Victor Edward Gailey	Mary Jan	ne Corbin	
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23. Part I Letter the disease, or complications that caused the death. Do not enter the mode of cyling, such as cardiact or respiratory arrest, shock, or heart and between Onset and Death (Preparant of the Complete) and the Complete of the mode of cyling, such as cardiact or respiratory arrest, shock, or heart and Death (Preparant of the Complete) and the Complete of Cardiovascular Disease or conditions, if any, leading to immediate cause or injury that initiated events resulting in death). Last contributing to death (Disease or injury that initiated events resulting in death). Last contributing the death of the Complete of Cardiovascular Disease or conditions, if any, leading to immediate cause of the complete of cyling, such as cardiact or respiratory arrest, shock, or heart and Death (Disease or conditions, if any, leading to immediate cause of the complete of cyling, such as cardiact or respiratory arrest, shock, or heart and Death (Disease or conditions, if any, leading to immediate cause of the cause of the complete of cyling, such as cardiact or respiratory arrest, shock, or heart and Death (Disease or conditions, if any, leading to immediate cause of the cause of the complete of cyling, such as cardiact or respiratory arrest, shock, or heart and Death (Disease or conditions). 23a. Atheroscierotic Cardiovascular Disease or conditions and the complete of complete or cause of death? 25b. Signature and the cause of death (Disease) and the complete or cause of death? 25c. Users number of Death (Check on) one of the cause of death? 25c. Was case referred to medical complete or complete or cause of death? 25c. Was case referred to medical complete or cause of death? 25c. Was case referred to medical complete or cause of death? 25c. Was case referred to medical complete or cause of death? 25c. Was case referred to medical complete or cause of death? 25c. Was case referred to medical complete or cause of death? 25c. Was case referr	L. Pages I and tment of Healt ortant: If item y or other tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	position (Name of cemetery, rother place) Cemetery 11/1	Date 20c.	c. Location - City or Town, State
Approximate interval property and a consequence of continued and path to the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or conflictions in the cause of the death.) Sequentially list conditions, if any, leading to immediate disease. Enter Underlying Cause (asses. Ente	Dermit Depar Impo	1 1	Mal & Pric M01452 Be	RUZO ANNADOLIS RO .	. Halernor	TOP WILL / L///
The Females of Death (Check only one) 23d. Date of delivery Month Day Year Pregnancy 23d. Date of delivery 23d. Date of d	∖/Medical £xaminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Atherosclerotic Cardiovascular Di Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		respiratory arross,	Between Onset and
By-Pass X3 1	death certificat	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fegnant at time of death 5 0	Other (Specify)	incy	Month Day Year
25. Was case referred to medical examiner? 1	requires that been signed bould be deta	þ		underlying cause given in Part I.	1 Yes 2	No 3 Probably 4 Unknown 24b. Were autopsy findings available
Second S	certificate har	B.	examiner?		performed? 1 Yes 2 N only one)	death? No 1 Yes 2 No
The second of the cause (s) and manner as stated. 29b. Signature and title of certiffer 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) November 11, 2011 30. Name and address of person who completed cause of death (Item 23a)		P	1 Ves 2 No ruspital 1 Inpatient 2 Ver ER/Outpatien 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of	of Injury 28c. Injury at Work? 2		
Anul Julian Month, Day, Year) O.C.M.E. November 11, 2011 30. Name and aedress of person who completed cause of death (Item 23a)			3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street (Specify)		or Town, State)	
Anul Arithul MD 30. Name and aedress of person who completed cause of death (Item 23a)	o the H. //thin 24 fo the F. //complete	₃dica	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	urred at the time, date and place, and di jation, in my opinion, death occurred at	due to the cause(s) and the time, date and pla	id manner as stated. ace, and due to the cause(s)
30. Name and aedress of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			29b. Signature and title of certifier Panusk fyrithads, MD			
	18	5		00 W Baltimore Street, Baltim	nore MD 21223	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley Ann Gill November 10, 2011 7:30 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Gilchrist Hospice Towson Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs **Funeral** 213-26-3844 84 Director 1 □ M 2**X** F August 14,1927 Baltimore, MD. Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Maryland Baltimore County Lutherville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 814 Branford Circle 21093 United States items ? Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒No
If Yes, Give "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) N/A Jones Lighting Specialist Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of ir traumatic ever ပ George Warnbold Erma Kirkwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Carver L.Gill (Husband) 814 Branford Circle Lutherville, Maryland 21093 t: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Maue of Different Processing Commercy, crematory or other processing Commercial Carriers Monchy Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once, (Baltimore County) Nov. 14, 2011 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Signature of Funeral Service License Seffrey L.Gair, Sr. O.S. 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.

Lic. #M00677 2325 York Road Timonium, Maryland 21093-2215 Lic. #00671 Peaceful Alternatives Funeral and 2325 Work Road Timonium, Many shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ hepatorenal disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Circhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 2411 Examine Due to (or as a consequence of): and the burial-trai resulting in death) Last Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Live according Pregnant at time of death Por Month Day ed by the at detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ hypertension, coronary arting deserte 2 No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy this certificate 2 🗌 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific. 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be completely filled in by the Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the within To the 29b. Signature d title of certifie 58 303 November 10 2011

DHMH 17 Rev 06-2011

State Registrar 6701

Charles St Towson MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

COMPLES UND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36123 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lore tta 3:00 P M COINS nres Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center
5. Social Security Number 6. Sex 7. Age (In yrs. last b <u>Bel</u> 9. Birthplace (State or Foreign Country)
North Carolina 8. Date of Birth (Month, Day, Jan 2, If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🂢 F Days Hours 216-48-4815 **Director** 64 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 Yes 2 X No MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21085 USA 101 Philadelphia Road Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No white 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) healthcare dental assistant unk unk Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Virginia Teague Irving Billings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
401 Mountain Road Fallston, MD 21047 19a. Informant's Name/Relationship (Type, Print) 401 Mountain Road Fallston, MD permit. Page 1 and 2 st Department of Health a Important: If item 27 is Michael Goins/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) in stat Signatur of Funeral Services State Anatomy Board 655 W. Baltimore Street Raltimore MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Bacteremia Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mo ths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours a "er death.

To the Funeral Director: After this certificate has been signed to the Funeral Director, page 2 should be or 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 N 25. Was case referred to nedical examiner?

1 Yes 2 No Be (Division of Vital 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) P63653 November 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shawn UPPER ChesapeakE Drive Bel AMI 2/014

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

NOV 1

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ 10:08 AM George Louis 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Harbor If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min June 17 1930 1 X M 2 🗆 F 217-24-7562 81 Marvland Director Usual Residence of Decedent 23a or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location Baltimore Direct Maryland Anne Arundel 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21225 USA 421 Prince Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced Year or Dates. Korea 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Property Management Unknown Landlord Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert R. George Reaver Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ann Marie George-Fell (Niece) 1928 Sulphur Spring Road, Baltimore, Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 11/16/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniiak Funeral Home, P.A. Signature of Fun ral Service Licensee Kevin E Ecker 237 E. Patapsco Avenue, Baltimroe, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melanoma Metastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner than Wre Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine than burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for the completed filled in by the funeral director, page 2. in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☑ No 2 M No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 12 th 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street 300

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:08 PM onstance 2011 November Medical 4a. Facility Name (if not institution, give street and number **Examiner** Location of Death 4c. County of Death Sinai Hospital of Baltimud more 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-28-7093 **Director** 1 M 2 M -18-MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b Counts City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Constance 10e. Street and Number 10g. Citizen of What Country? 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done durin lift). DO NOT use retired) 25 (Specify only highest grade completed) ondary (0-12) College (1-4 or 5+) Be (Father's Name (First, Middle, Last) ဂ္ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of 20c, Location City or Town, State Baltimore, 20b. Place of Disposition (Name of ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Sepsis 1 day disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Stroke Be Completed I 1 Yes 2 No 3 Probably 4 Unknown blading Gastrainkstinal 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an o the Hospital or Attending Physician: The law within 24 hours after death.

o the Funeral Director; After this certificate has I autopsy performed 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Cechus Yshii - Tamashio RES-000 November 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cecilia Yshii - Tamashiro Sinai Hopital of Balhmore MD 31. Date filed (Month, Day, Year) State NOV 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19 2011 9:10 PM OCTOBER HARRY HOWARD JR. FISHER Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** nth, Day, Ye Months Days Hours Min. NORTH CAROLINA **Director** FEB. 1937 241-52-7904 1 X M 2 🗆 F 74 Usual Residence of Deced 28a-f shov 10b. County 10d. Inside City Limits 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 1X Yes 2 ☐ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4417 NASH STREET N.E. 20019 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 BLACK 1 and 2 should be filed within 72 hours after the atth and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exar If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE TRANSPORTATION DEPARTMENT 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CELESTINE HILL FISHER HOWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is u 4417 NASH STREET N.E. WASHINGTON, DC ANNIE S. HOWARD/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State RESURRECTION CEMETERY 10-29-11 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Inter the d'stase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ FATAL CARDIAC ARRHYTHMIA Medical Due to (or as a consequence of Examiner MYOCARDIAL INFARCTION Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perform death? certificate 1 ☐ Yes 2 🗶 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA ျပ After this

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Hospital or Attending ours after death. eral Director: Aft filled in by the fur hin 24 hours a the Funeral D πpletely filled

Natural Accident work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertification

28c. Injury at

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SION BEKHANE 3001 HISDI

28a. Date of injury (Month, Day, Year)

heverly mo 20183

28d. Describe how injury occurred

Registrar

Certificate:

Medical

27. Manner of Death

5 Pending

within 2 To the I

28b. Time of

iniury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:55A M Ruth Naomi Hamilton 201 Novembe Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner sedale timore Sax ospita Jare If Under 24 Hrs ge (In yrs. last birthdav) If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🛛 F Months Hours Min 05/25/1930 Director 212-28-3968 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland Baltimore 1 🗌 Yes 2 🛣 No Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 22 Strawberry Court 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2xxxNc If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Completed 3X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Cup Manufacturer other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Milburn King Harriet Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Hamilton, Ruth Picarello (Daughter) 731 Danville Circle, Bel Air, Maryaldn 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial 11/11/2011 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral HOME, P.A.

107 013 Fostern Avenue, Essex, Maryland 21221 Signature of Fune al Service Licensee 23a. Part 1. Epifer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Diratory percarbia dise or condition re ting in death) or condition Medical Du t (or as a consequence of): Examiner Ecquernially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ pertension, Atheroscleratic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial 24a. Was an autopsy performed? Yes 2 No has this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Residence 6 \(\sum_{\text{Other}}\) Other (Specify) Hospital: 1 🖵 Yes 2 🗹 No ER/Outpatient 3 DOA 1 🗹 Inpatient 2 🗆 28a. Date of injury (Month, Day, Year) 27. Manner of Death completed filled in by the funeral 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Matural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dat Year)

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State Registrar D69540

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SS13 Wallhan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shah

NOV 1 4

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 10:50 P^M November Bettv Jeanne Horn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson 8. Date of Birth (Month, Day, Year)
Nov. 17, 1922 Social Security Number If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 340-14-7499 Director 1 □ M 2X F 88 Yrs Kansas show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 🗆 Yes 2 🔀 No or 28a-f Maryland Baltimore Phoenix 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a U.S.A 2 Thorndvke Garth 21131 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Millard Snook Daisy Inez Box 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ant: If item 27 is William E. Horn 2 Thorndyke Garth Maryland 21131 Husband Phoenix. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date MD Vererans Ceme Garrison Forest Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once. o 11-18-2011 Owings Mills Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Part 1. Enter the disease, or complica shock, or heart failure. List only one complications of the complete shock of the complete sh Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ days disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown 5 Other (specify) ed by the a detached f 1 Yes 2 I been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe after death.

Director: After this certificate! Yes 2 XNC 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 🙀 No 1 Natural 5 Pending Fall November 3 Toll NOON 2 Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Assisted living Facility 8101 Bellona Ave, To the Hospital within 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌

State Registrar and title of certific

AMON

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAMES

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32. Registrar's Signatu

6701 N. Curly

58303

NOZWOT

29d. Date signed (Month, Day, Year)

November 8 2011

11-08078 Jo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n C. Hines	1	State of Maryland / Department of large State State of Maryland / Department of large State Stat	⊣ealth and Mental H Death	ygiene Reg. N	201	1 3612
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Da	av Year	3. Time of Death
dical Exami	ner	John C. Hines	o. City, Town, or Location of Death	October 27, 2	2011 4c. County of Death	2340 nrs
		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	Annapolis		Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		/M/DD/YYYY) 9. Birth Foreign	
Director		220-16-8741 1XM 2F 84 Yrs.		Sept 25	, 1927 P&M	hsylvania_
япу	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio	n		i i	10d. Inside City Limits
* .	5	MD Anne Arundel Galesv				1 Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatie event, the Medical Examiner must be notified at once	Director	10e. Street and Number 4736 Woodfield Road Box 236	10f. Zip Code 20765	10g.	Citizen of What Countr USA	ry?
ith the 23a o		11 Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - America	an Indian, Black,
leath w	Funeral	1 Never Married 2 X Married Armed Forces? If Yes	s, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after d	by F	3 Widowed 4 Divorced If Yes, Give Year 145-46	Yes 2 X No specify: s Usual Occupation (Give kind of	work dono	Specify: whi	
hours natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use ret	tired)	b. Kind of Basinessian	a aa.,
21215-0036 wild be filed within 72 Mental Hygiene. marked other than c event, the Medical	Completed		fighter		public se	rvice
Hygier of the Mi		17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Mai		
d be fi fental narked event,	Be	Charles FRanklin Hines 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing	Myr Address (Street and Number or	tle Groff Rural Route Numbe	r, City or Town, State,	Zip Code)
MD 2 id 2 shoul ilth and N in 27 is in aumatic	٩	(),	Woodfield Road			765
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours al nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural other traumatic event, the Medical Examin		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposit crematory or other	tion (Name of cemetery, er place)	Date 2	0c. Location - City or T	own, State
Pages lent of int: If		4 X Donation 5 Other Specify:				
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than injury or other traumatic event, the Medical	1	21. Singuare of Funeral Jervice Licenses	ame and Address of Facility Late Anatomy Boa	rd 655 W.	Baltimore	Street
Physician	\dashv	23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the	1 timore, MD 21 e mode of dying, such as cardiac	201 or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical		failure Listonly one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease)				Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	P	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	miner	C. Disease or injury that initiated Number of Aparth New York Company (New York) New York (New York) New Y				
scuted and transit	Exa	events resulting in death) Last Due to (or as a consequence or): d				
O, e be executed sician and burial - transi	edical	UNPENDED AMENDED				
68760 certificate bending physical	51	IF FEMALE: 23b. Was decedent pregnant in the 2. Live birth 2. Fet	al death 3 Ectopic pregr		23d. Date of delivery Month D	ay Year
Box 6876(c) death certificate the attending physed for use as the b	iciar	past 12 months? 4 Pregnant at time of death 5 Oth	ner (Specify)			
BO) he death the att	Physici	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the un	ndertving cause given in Part I.	23e. Did toba	acco use contribute to t	the cause of death?
i, P.O. ires that the signed by I be detach	by	Chronic Obstructive Pulmonary Disease; Renal Failure		1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
ords, F w requires us been sign should be	Completed			24a. Was an autopsy	24b. Were aut	topsy findings availab ompletion of cause of
Recol The law cate has I page 2 sh	ldmo			perform 1 Yes 2	ed? death?	
tal Rec cian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check			
of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient		sing Home 5 Re	esidence 6 Other	:
ion of tending Pheath.		27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of In	njury 28c. Injury at Work?	28d. Describe no	w injury occurred	
Division tal or Attendin rs after death.	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, stree			eet and Number or Ru	ral Route Number, Cit
Division ospital or At hours after dineral Direct y filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	te)	
Hos 24 h Fun		29a. Certifier (Check only Department) Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigate	red at the time, date and place, ar	nd due to the cause(s) and manner as state	ed. e cause(s)
To the Hos within 24 h To the Fur completely	Medical	and manner stated.	29c. License number		29d. Date signed (Mor	
	1	29b. Signature and title of certifier	O.C.M.E.	ļ	October 28, 2011	1
~		30. Name and address of person who completed cause of death (Item 23a)				
		Laron Locke MD. Assistant Medical Examiner 900 W. Ba	ıltimore Street, Baltimore,	, MD 21223		
S Regis	tate	**************************************	el. I			
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17 146V 17		OCAF				

State of Maryland / Department of Health and Mental Hygiene 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 3:55 Рм November Anne Healy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Towson Baltimore Gilchrist If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 212-32-1685 Months 1 🗆 M 2 👿 F Director 97 1913 Connecticut show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1

Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 3900 N. Charles Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14. Race - American Indian, ıral", or iten Examiner ı Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ Teacher/School Administrator Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental of Health and Mental fitem 27 is marked 2 Florence Bragg Frank E. Healy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 Roland Avenue; Baltimore, MD 21210 <u>Kitty De</u>vlin friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 € remation 3 - Removal from State Department o Important: If any injury or once, ò Other (Specify) Hilltop Service Corp. 11/14/2011 Towson, MD 4 Donation 1050 York Road 21. Signature of Fu Towson, MD 21204 Ruck Towson Funeral Home, Inc. t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) to (or as a consequente of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) anding physician and use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year rate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Ves Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 HOther (Specify) NUS P(4 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. '2 [3 [only one) 29b. Signature and title of certifier 29c. License number Nevember 10 2011 8303 13 BM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NVO CHNIES 6701 Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 500 er Wayne Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 🛛 M 2 🗆 F Months Min. Month, Day, Year) 1/07/1946 Washington, Yrs. **Director** 578-6**0**-0226 64 Usual Residence of Deceden: show 10b. County with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🔀 No MD Columbia Howard 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral U.S.A Sandrope Court 21046 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Government Management injury or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 <u>Eileen</u> Dye Howard Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine Hunt / Wife Sandrope Court, Columbia, MD 21046 8801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🛮 Donation 5 🗆 Other (Spacify) Anatomy Gifts Registry 10/31/2011 Hanover, Maryland 21. Signature of uneral Service Liv 22. Name and Address of Facility Anatomy Gifts Registry any Ste. P, Hanover, MD 21076 7522 Connelley Dr., or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dise Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam burial-transi that initiated events resulting in death) Last CERTIFICATION APPROXED BY MEDICAL EXAMINER and Due to (or as a consequence of): physician Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed pinous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law 24 hours after death.
 Funeral Director: After this certificate has page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No #230+ Division of Wtal 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannur of Death 1. Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Year) (Month, Day, Year) injury 5 Pending torlet Accident Suicide UNK Investigation 6 Could not be Place of Injury - At hor building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Rouge Number, City or Town, State) \$80/5and COPC CT 4 Homicide determined tome 21044 MD Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 01386 2011

State Registrar 30. Name and address of person who

MIR

S. Greene St Baltimore MD 21201

ompleted cause of death (Item 23a) (Type, Print)

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 361 Certificate of Death i. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ vemo Medical 4a. Facility Name (if not institution, give street and number) County of Death Town, or Location o **Examiner** 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth curity Number 1 ☐ M 2 🔀 F Hours Country) 2M247 P3,2341) MD 220-18-5174 87 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🍱 No Sykesville MD Carrol1 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral USA 21784 710 Obrecht Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Her Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ဝ Anna Lorena Miller Charles F. Peach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21163 10510 Davis Ave., Woodstock, Doris Mathena/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alphonsus Cemetery 11/12/2011 Woodstock, MD uneral Service Licens 21. Signature of ²²Burrier-Vueen Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784

Ph_sician/ Medical Examiner physician s the burial Division of Vital Records, P.O. Box 68760

attending properties for use as

ed by the a

Funeral

Director

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death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

iral", or items 23a or 28a-f sho Examiner must be notified at

"natural", or

permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical

as s certificate has k lirector, page 2 s

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MP

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32. Regist

To the Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, To the F

	23a. Part 1. Enter the disease, or comp shock or heart failure. List only or Immediate Cause (Final disease or condition	lications that caused the death. Do not e e cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death	,
Completed by Physician/Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or inipury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No g □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
ed by Pr	Part II. Other significant conditions of	ntributing to death but not resulting in th	ne underlying cause given in Part I.		use contribute to the cause of death?	wn
Somplet				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	ie f
Be (25. Was case referred to medical		26. Place of Death (Che	eck only one)		
E O	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA Other: 4 Nursing	Home 5 Residence	6 Other (Specify)	
icate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Timinjur	e of 28c. Injury at	28d. Describe how inj		
Medical Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
l edica	(Check 2 Medical Exami	ician: To the best of my knowledge, dea ner: On the basis of examination and/or in a Practioner: To the best of my knowledge	vestigation, in my opinion, death occurred	at the time, date and pla-	ce, and due to the cause(s) and manner st	ated.

29c. License number

7,0 chricht

29d. Date signed (Month, Day, Year)

21784

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** JOHN HYMAN 6: MAM NOVEMBER OF 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITA2 BON SECOVRS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year 07-18-41 7. Age (In yrs. last birthday) 6. Sex **Funeral 1X**□XM 2□ F Months Days Hours 213-36-5678 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" ~ : any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location XIXIYes 2 □ No **Funeral Director** MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 929 East 41st. 21218 Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 1 □Yes 2X No Specify Specify: American Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morgan Trene Frank Hyman ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120719a. Informant's Name/Relationship (Type. Print) Grand 6743 A. Windsor Mill Road Baltimore, MD. <u>LeTronda</u> Brooks-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State King Mem. Pk. 11-15-11 Randallstown, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HEART DISEASE TERIOSCLEROT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ZUNG DISTASE CHRONIC OBSTRYCTIVE and Due to (or as a consequence of): the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ULCER DELUISITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ENCEPHALOPATHY, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform HYPERTENTION 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 □ No after death Director: 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 123300 NOVENOBER DR 2011 MD BUN SELOVES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR 31. Date filed (Month, Day, Year NOV 1 4 2011 32. Registrar's Signature

Registrar

			For State	State	of Maryla		artment of I			lental Hy	giene	20	1	36134
	_		Registrar 1. Decedent's Name (First, Mi	tdo (ast)		Cer	tificate of I	Jeatr	7	2. Date of De	Reg. No	o. <u>Z</u> U	1 1	3. Time of Death
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Jak Cag	Examir		4a. Facility Name (if not institu		,		4b. City, Town, o				40	c. County of	. Ar	
\geq			FRANKLIN SQ 5. Social Security Number	16. Sex	Spital	Centers. last birthday)	If Under 1 Year		er 24 Hrs.	8. Date of Bir	-th		_	olace (State or Foreign
H	Funeral Director	П	216 - 92-3623	1 💢 M 2 □ F	46	Yrs.	Months Days	Hours		03/12/			Coun	
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	n with	Funeral	1512 Aldeney Ave	nue			21220				U.S	S.A.		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status 1 ☒ Never Married 2 ☐ I 3 ☐ Widowed 4 ☐ Divor	Armed Fo	2 🕱 No ve		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 💢 No	an, Mexic	an, Puerto F			14. Race - Black, Specify:	White,	
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Baltimore, Maryland 21215-0036	age 1 ant of H		1 🗆 Burial 2 🔀 Cremat		n State	b. Place of Dispo cemetery, cren illtop Sv	natory or other pla	ce)	11/11	/2011		_ocation - Ci		
altin	permit. Pa Departme Importan any injur		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Servi		- 11		2. Name and Addre	ss of Fac				son, Mai Inc.	yrai	lu
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. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 🗆 Fignant at time	etal death 3	Ectopic pregnan Other (specify)	су			1,9	23d. Date Month		Day Year
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Division of Vital Records,	The law req ate has bee page 2 shou	Completed								24a. Was auto perfi 1 \square Yes	psy ormed?	prid dea	or to co ath?	psy findings available mpletion of cause of 2 No
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Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to	Il Certificate:		uld not be ermined 28e. Place build	e of Injury - At ing, etc. (Spe	t home, farm, str	eet, factory, office		2	28f. Location (City or To			or Rurai	l Route Number,
	ne Hospit in 24 hour he Funera pleted fill.	Medical	(Check 2 Medic	ring Physician: To the la al Examiner: On the ba ring Nurse Practioner:	sis of examina	ation and/or inves	tigation, in my opini	on, death	occurred at	the time, date	and plac	e, and due to	the ca	iuse(s) and manner stated.
_	Vith Com		29b. Signature and title of cert	fier			29c. Licens					ate signed (/		
			100					1-2:	364			11-1	0 -	2011
			30. Name and address of pers OR Devadat 31. Date filed (Month, Day, Yea	Ta A Sar	wate	4000	FRANKLI	n Sa	Ruel	e DR	Ba	Lton	1d	21237
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:30 P M Karen Lynn Honeywell 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville 9116 Orbitan Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Hours 1 M 2 X Months Dec. 27, 49 Toledo, Chio 220-84-7680 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 ☐ Yes 2 🛣No Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any hiury or other traumatic event, the Medical Examiner must be a Funeral United States 21234 9116 Orbitan Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. 1XXNever Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Data Entry Clerk Data Processing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Russell Lenard Emil Honeywell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9116 Orbitan Road Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) Ronald Honeywell, Sr. (Brother) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of November 14, 1 Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel-Bel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ Drona disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence attending physician Physician/Medical Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Day Month Year 4 Pregnant 5 Other (specify) Pregnant at time of death signed by the Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 X No After this certificate 25. Was case referred to medical examiner? Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 2 XNO 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending death. 1 Tes 2 🗌 No Investigation Accident after death completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Panayiotis A. Baltatzis,

NOV 1 4 2011

M.D.

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

8113 Harford Road, Suite 100 Parkville, MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia P∽dical Exami		Decedent's Name (First, Middle, Last) Joshua John Hanna		-		2. Date of Dea Month November	Day Year	3. Time of Death 1734 hrs
)		4a. Facility Name (if not institution, give street and number)			or Location of Deat		4c. County of Death	
Funeral		University Hospital 5. Social Security Number 6. Sex 7. Age (In y.	rs. last birthday)	Baltimore	ear If Under 24Hr	s. 8. Date of Bir	th(MM/DD/YYYY) 9. Birt	holace (State or
Director		220-33-7388 1×M 2 F 2	1	Months Da			Foreig	
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21215-0036 ould be filed within 7 Mental Hygiene, marked other than c event, the Medica		17. Father's Name (First, Middle, Last) John A Hanna					Maiden Surname)	,
2121; ould be fill d Mental F marked	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailí	ng Address (Stre		L. Rutk Rural Route Nun	OWSK1 nber, City or Town, State,	Zip Code)
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more, MD 2 Pages 1 and 2 shou nent of Health and In net: If item 27 is no rother traumatic		1 Burial 2 X Cremation 3 Removal from State	Evans Fu Bel Ai:	herat Ch	apel Nov	. 12 , 2011		
Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr	ł	4 Donston 5 Other Specify: 21. Sign 3.4 of Funeral Service Licensee					emation Ser	ll, Maryland
ம் உட்தியி Physician		23a. Part I. Enter the disease, or complications that caused the de	3	Newport	Drive Fo	rest Hi	II. Maryland	21050 Approximate Interval
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O. Box 68760, that the death certificate be need by the attending physic detached for use as the but	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of put in the past 12 months? 23c. If yes, outcome of put in the past 12 months?	2 F	Fetal death 3	Ectopic pregn	ancy	23d. Date of delivery Month D	ay Y ear
the deat y the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but n	not resulting in the	Linderlying cause	given in Part I	23e Did to	obacco use contribute to	he cause of death?
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tal Rec			_			1 ✔ Yes	rmed? death? 2 No 1 ✓ Ye	s 2 No
Vital hysician this certi	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No . Hospital: 1 ✓ Inpatient 2	ER/Outpatier		ce of Death (Check		Residence 6 Other	
Division of Vital Records, P.O. Box 687 is low Attending Physician: The law requires that the death certific its after death. *I Drector: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the content of the state of		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) NoV 5, 2011	28b. Time of 1554 hrs	· · · _	ury at Work? Yes 2 ✔ No		how injury occurred hicular collision	
> 3 4 5 5	Certification:	2 ✓ Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local St		eet, factory, office	building, etc.	or Town, S	Street and Number or Rustate) ville Road, Churchville	
Division of Vital Rec To the Hospital of Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled it by the funeral director, page	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated						
F > F 8	2	29b. Signature and title of certifier			nse number		29d. Date signed (Mor	
	-	39. Name and address of person who completed cause of death (I	Item 23a)	1 0.0	.M.E.		November 6, 201	
		Laron Locke MD. Assistant Medical Examine	er 900 W. E	Baltimore Stre	et, Baltimore,	MD 21223		
St Regist		31. Date filed (Month, Day, Year) 32. Physitar's Sign	nature 2	arlas				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 361 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FLORENCE MARIE HEILIGER **Physician** 9:45 P M Nov. 8, 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 4130 Annapolis Road 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)
Nov. 1, 1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland Days Hours Min 1 ☐ M 2 🕮 F 217-12-5385 89 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County Department of Health and Mental Hygiene. Important: "or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show all important: if item 27 is marked other than "nation of the modified at any injury or other traumatic event, the Modical Examination instituted at once. Baltimore 1 ∏Yes 21 No Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 21227 4130 Annapolis Road USA Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 X No Specify. Specify: à White 3 X Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Highland Inn Restaurant Cook Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland should be Dora Mae Noll Oscar Grim ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ms. Kimberly Ward (Granddaughter) 216 Falcon Drive, Pasadena, Maryland 21122 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 11/16/2011 Glen Burnie, Maryland Atlantic Crematory, LLC 4 □ Donation 5 □ Other (Specify) 21. Signature of Functor Service Licensee Kevin E Ecker 22. Name and Address of Facility Mcully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence of: Examiner Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2XINo 1 🗆 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Puneral Director: A filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) ocistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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11/8/2011

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FLorence

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Norman Jordan 45AM Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital ankl auare IMORE **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F 215-56-0410 63 1070471948 Maryland Director Usual Residence of Decedent 28a-f shov 10b. County death with the Maryland 10a State must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Essex 1 🗌 Yes 2 🄀 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 949 Barron Avenue 21221 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Force 0 2 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 ☐ Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event" 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Pipe Fitter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Vernon Jordan Mildred Shimanek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lana Baker (Sister) 4102 Autumn Drive, Jarrettsville, Maryland 21084 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 11/15/201 Bayview Crematory Baltimore, Maryland 21. Signal Funar I Succession I in see 22. Name and Address of Facility,
Bruzdzinski Funeral Home, P.A. Old Eastern Avenue. Essex, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ORDDARY Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Day 2 No ed by the a detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown heart Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗹 No Other: 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title 29d. Date Ligned (Month, Day, Year, 30. Name and address of person v o completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER BAR 20 1 1 1 0:45 ам **ALEXANDER** JAGODZINSKI Medical RICHARD 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE FUTURECARE NORTH POINT BALTIMORE 5. Social Security Number **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days OCT. Day, year) 1934 Months Hours **Director** ^CMARYLAND 218-28-8546 77 Usual Residence of Decedent 28a-f show 10a. State notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE 1 XYes 2 ☐ No ò 10e. Street and Number 10f. Zip Code rral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 603 S. ANN STREET APT. U.S.A. 407 21231 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force ρ 1 Never Married 2 Married 1 Yes 2 No Black, White, etc Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Completed Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER NATIONAL BEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evente. မ NICK **JAGODZINSKI** LENA WASHIEWSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARMELLA LANE/NIECE 402 N. LINWOOD AVENUE, BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State SACRED 4 ☐ Donation 5 ☐ Other (Specify) HEART OF JESUS 11/10/11 BALTIMORE, MD Signature of Funeral Service Licensee 22 Name and Address of Facility ER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final THEROSCLEROTIC Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dus to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day 2 No Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' Yes 2 this certificate å 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: မှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ours after death leral Director: A filled in by the fi Accident 1 🗌 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours To the Funeral Medical Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly one) 29b Signature 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 9106

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1/09/2011 5:00p Physician/ Jimmie Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Care 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace , Country) MD 7. Age (In yrs. last birthday) **Funeral** Days Hours 51 04/10/1960 212-84-7146 1**X** M 2 □ F **Director** Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at **Funeral Director** MD Baltimore Middle River 1 Yes 2XXNo 10g. Citizen of What Country? Of. Zip Code 10e. Street and Number 21220 USA 20 Chadford Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examina one. 1 Never Married 2 Married þ 1 ☐ Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Public Works Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathleen Gail Packer ပ္ Jimmie L. Jones 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Chadford Ct., Middle River, MD 21220 19a. Informant's Name/Relationship (Type, Print) Sharon Jones / Wife 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State W. Arundel Crematory 11/15/2011 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 Mala 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ochocollules Physician/ winter disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): nantis Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or i that initiated events Due to (or as a consequence of): resulting in death) Last Medical Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🎾 Yes 2 🗌 No 3 🗌 Probably 4 🗌 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 X No 4 Nursing Home 5 Residence 6 Wother (Specify) W SOL CL 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 1 Natural Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred s after death. 5 Pendina Investigation ☐ Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUES 6701 (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed

32. Registrar's Signature

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			For State Registrar			, , , , , , , , , , , , , , , , , , ,		tificate					Reg. N			36	141
	Physicia	an/	1. Decedent's Name	e (First, Middle, Las 1 Jump	st)							2. Date of D	eath)ay	Year	3. Time of I	
. when	Medi Examir	cal	4a. Facility Name (if		street and number)			45 City	Faura or	Location	of Death	11			011	350	РМ
	EXALISII	iei	FRANKLin			Soite	2.1	4b. City,		sed			4			nore	
10	Funeral	Г	5. Social Security No. 215-20-	umber 6. Se	ex 7. Aç	ge (In yrs. las		If Under Months		If Under Hours		8. Date of B	irth Day, Yea <u>r</u>)		9. Birth Cour	place (State or	Foreign
	Director		Usual Residence of		□ M 2 🔀 F	8	5 Yrs.					July	2,1	926	Mary	land	
	Maryland 28a-f shov otified at	Director	10a. State	10b. County Baltim	ore	10c. City,	Town or Loc	ation Parkv	ille							10d. Inside City	
	s 23a or 3	Funeral D	10e. Street and Nun 8800 Wal		d Apt 4110	0		10f. Zip	Code 212	34			10g. C	USA	Vhat Cou	ntry?	
A 9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married . 4 X Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.)		/as Decede Yes, speci				cify Yes or No Rican, etc.))-		k, White,	ean Indian, etc. ite	
ح (ح ۱۸ 21215-0036	ed within 72 hou Hygiene. other than "nati ent, the Medica	Completed	(Spec Elementary/Seco 12	15. Decedent's Ed acify only highest gra ondary (0-12)	ducation ade co <i>mpleted</i>) College (1-4 or 5	5+)	life. DC	ent's Usual ind of work NOT use cher	done di		t of workin	ng	1	Kind of Bu		dustry ounty V	7A
	12 should be filed vith and Mental Hyg 27 is marked other r traumatic event,	To Be	17. Father's Name (F	First, Middle, Last) 5 Howard A	Adams					18. Moth	er's Name rgare	(First, Middle et Gal]	e, Maider	n Surname Y	a)		
$\int_{\mathcal{A}^{M}} \rho V$ altimore, Maryland	and 2 shou Health and tem 27 is m		Judy Bres							nd Numbe Cou	er or Rural rt, P	Route Numb Parkvi]					
يار timore	permit. Page 1 a Department of I Important: If ite any injury or ot		4 Donation	Cremation 3 5 Other (Specify		Evan Crene		av Ch	ir		ov.	10 ,2 011	For	est 1	Hill,	own, State Maryla	nd
Bal	permit. Departr Imports any inju		21. Signature of Fun	ieral Service Licens	ns Food	du-	_ E	Name and Zans 300 H	Address Fune ario	s of Facility ral (rd Ro	hape	l and Parkvi	Cren	matic Mary	n Se Tand	ryjces 2†234	
		П	23a. Part 1. Enter the shock, or hear	ne disease, or comp t failure. List only or	olications that cause ne cause on each line	d the death.	_									Approximate Interval Betw	990
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal c	death 3	Ectopic pr Other (spe		/					e of deliv	ery Day Ye	ar
ds, P.0	luires that to an signed by uld be deta	þ	Part II. Other signific	cant conditions co	ontributin g to death b	out not result	ting in the un	derlying ca	ause give	en in Part I	l.					ne cause of dea	
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	For State Registrar	Otate of Ma	-	Certificate o			Reg. No. 201	1 36142
ician/	1. Decedent's Name (First, Middle, Last		AB'INL	5		2. Date of Dea Month	Day 2 Year	3. Time of Death 3', 03 P M
miner	4a. Facility Name (if not institution, give a BALTIMBREWASHING)	Street and number)	L CE2178	4b. City, Town	, or Location of De	eath	4c. County of De	ath
ral tor	5. Social Security Number 6. Se	7. Age	(In yrs. last birtho	lay) If Under 1 Ye	ar If Under 24 F	lin. 8. Date of Birt (Month, Day Feb 8,		sirthplace (State or Foreign Country) unk
Ď	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
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To Be	17. Father's Name (First, Middle, Last)			un	k 18. Mother's i	Name (First, Middle,	Maiden Surname)	unk
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ouce.	4 Donation 5 Other Specify 21. Signature of Euneral Specific Licens		ctor	State and Ad		ard 655 W. 201	Baltimore	Street
in/ cal ner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	he cause on each line. a. ${2}$	he death. Do not	t enter the mode of o			rest,	Approximate Interval Between Onset and Death
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	C	consequence of)					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 1 9 Unknown	Fetal death	3 Ectopic pregr			23d. Date of o	delivery Day Year
þ	Part II. Other significant conditions co	ontributing to death but	t not resulting in	the underlying cause	given in Part I.		obacco use contribute Yes 2 \(\square\) No 3 \(\square\)	to the cause of death? Probably 4 Unknown
Completed				P.		24a. Was auto perfo 1 \(\sum \text{Yes}\)		autopsy findings available o completion of cause of ? Yes 2 No
To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 ER/Outp	* 1	Place of Death (Control of Dea		dence 6 ☐ Other (Sp	ecify)
Certificate: 1	27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	28b. Tir	ne of 28c. In	njury at /ork? Yes 2 No	28d. Describe h	now injury occurred	
Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, fam (Specify)	n, street, factory, office	e	28f. Location (S City or Tov	Street and Number or F vn, State)	Rural Route Number,
Medical	(Check 2 Medical Examin	sician: To the best of m ner: On the basis of exa se Practioner: To the b	mination and/or i	nvestigation, in my or	oinion, death occurr	red at the time, date a	and place, and due to th	ie cause(s) and manner stated
Medical Certifica	29b. Signature and title of certifier	J. Mond	col is	Dr	ense number		29d. Date signed (Mo. 1) 1 2 21	oth, Day, Year)
	30. Name and address of person who co	an ison	41 808 F	Pe, Print)	DRIVE S	NITE 27	CLEH BHRM	8 MD 21061
State strar	31. Date filed (Month, Day, Year) NOV 1 4 2		s Signature	harles				- 31
7/2009		700						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 4:17A Millard F. Kirk 20TT Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Carrol1 Sykesville Fairhaven 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours 09/11/11/20 1 🔀 M 2 🗆 F 91 164-18-3386 Pa. Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 Tes 2 No Sykesville Md. Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 7200 3rd. Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Navy
If Yes, Give
Year or Dates. WWII Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Engineering Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Alice Baughman Albert Raymond Kirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 3rd Ave Sykesville, Md. 21784. Betty L. Kirk(Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State All County Cremation 11/12/2011 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}Haight Funeral Home & Chapel PA P.O. Box 195 Sykesville,Md. 21784. . Signature of Fundat Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between enset and Death Immediate Cause (Final Ph. sician/ N Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a, Was an autopsy performed? Yes 2 No After this certificate has сотрете filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 00 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 2 🔲 No 1 Yes Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Tecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature an title of 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

11-0839	8
Charles	King

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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neulcai Lxaiiii	1161	CHARLES KING 4a. Facility Name (if not institution, give street and number)			b. City, Town, o	r Location of Deat	November 9, 2011 4c. County of Death			
,		820 W. Bel Air Avenue Room 215		Aberdeen Harford av) If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or						
Funeral Director		5. Social Security Number 6. Sex 412-72-3873	7. Age (In yrs. last		If Under 1 Ye Months Da		_	1947 Foreig	nplace (State or ARKANSAS untry)	
Aoy	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
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th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	itry?	
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2 hour:	ted	15. Decedent's Education (Specify only highes Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)			ation (Give kind of e. DO NOT use re		16b. Killd of Business/ii	idustry	
1036 Aithin 7 ene. or than	Completed	12yrs		DISA	BLED VE			N/A		
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212 ould be Menta mark	9 B							Zip Code)		
MD d 2 sho lith and n 27 is		Brenda K. King/Wife						n, Md., 210	01	
Ore, es l an of Hea If iter		20a. Method of Disposition 1XX Burial 2 Cremation 3 Remo		ace of Disposi ematory or oth	tion (Name of co er place)	.	Date	20c. Location - City or	,	
Baltimore, permit. Pages 1 an Department of He important: If ite	-	Donation 5 Other Specify: 21. Signature of Fuperal Service Licensee	GAR	RISON			-21-11		LS, MARYLAN	
Ba Depa Imp		Am		WI 12	LLIAM C 06 W NO	BROWN CORTH AVE	OMMUNITY	FUNERAL HO	ME-P.A.	
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ion of verting Ph. eath.	Ę	1 Natural 5 Pending	Month, Day, Year)	d 5:23		Yes 2 X No	unknown			
ViSion or Atturber de Directo in by t	Certification:	3 Suicide 6 Could not be 28e.	Place of Injury - At hom	ne, farm, stree	t, factory, office	building, etc.	28f. Location (S	Street and Number or Ru tate) 820 W. Be	ral Route Number, City	
Divi		4 Homicide (Specify) Hotel/Motel Room 215 Aberdeen, Md.								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To cor.	Š	and manner stated. 29b. Signature and title of certifier 29d. Date signed (Mo								
Aflu Brasself MD O.C.M.E.								November 9, 2011		
V		30. Name and address of person who completed Melissa Brassell, MD Assistant	I cause of death (Item 2 Medical Examine		. Baltimore	Street, Baltim	ore, MD 2122	23		
St	ate	MO	2. Registrar's Signatur	han	Kal					
Regist	rar	MUAT 4 COLL	censur po	1						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10,2011 William Elliott King 2:15 A.M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford County Bel Air 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1**X** M 2 □ F **Director** 215-22-4353 84 Baltimore, MD. Sept. 18, 1927 Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No Maryland Baltimore County Perry Hall 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 21128 United States 5136 Scenic Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc 9 2 □ No Army þ 1 Never Married 2 Married 1 Yes 2 No Specify. White Specify. "natural" 3 Widowed 4X Divorced Completed Year or Dates, W.W.II event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore Sun Paper Deliveryman N/A is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucien Minor King Elizabeth Alvirte Masemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Hall, Maryland 5136 Scenic Drive 21128 Mr. David W. King Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Exans Funeral Chapel and
Cremation Services, Inc. 1 Burial 2 Fernation 3 Removal from State (Harford County) Sunday 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licenses Licens Lic.#M00677 2325 York Road Timonium Maryland 23a. Part 1. Erker the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a come quence of): Exami Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The Yes 2 No 1 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending Division To the Hospital or Attendil within 24 hours after death. To the Funeral Director: Af M __ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Fractitioner: To the best of my knowledge, South secured at the time, date and place 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e Drive Bei Air, MD 31. Dale filed (Month) State Registrar

ORIGINAL

**** DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 14 per fh,g921,11/14/2011dbb
Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 November 9. **Physician** Curtis Lee Karn, Sr. 7:30 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 105 East Ostend Street Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 21, 1934 5. Social Security Number Funeral Days Months 215-30-9918 77 Maryland Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location show 10a State 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinatings to the rotified at ty Yes 2 □ No Director Maryland Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21230 U.S.A. 105 East Ostend Street Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 White Vibrietas 1 ☐ Yes 2 📆 🖈 o þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nr any Injury or other traumatic event, Ire Media once. Stockard Shipping and Elementary/Secondary (0-12) College (1-4or 5+) Clerk Terminal Corp. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Karn Jessie Heffer ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wendy Mizerovsky 105 Fast Ostend Street Baltimore, Maryland 21230 fiancee 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 remation 3 ☐ Removal from State Nov. 11, 2011 | Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cully Polyniak Funeral Home P.A. 21. Signature of Euneral Service Licenses 130 East Fort Avenue Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardto La/wavar 2 hm Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner to years Obstrake Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐Yes 2 ☐No 1 ☐Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation nours after death.

neral Director: Aft
y filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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30. Name and add

Year)

ORIGINAL

ress of person who completed cause of death (Item 23a) (Type, Print)

ST PAUL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 7019 Tarquin Ave Temple Hills Prince Georges 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. Davs Hours (Month, Day, Year, Country) 229-16-3465 **Director** 1 🖾 M 2 🗆 F Yrs Usual Residence of Decedent 96 July 15, 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7109 Tarquin Ave. 20748 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after "natural", 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. 43-46 Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Civil Servant Federal Government Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Lindsey Corinne Lindsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Lindsey - Wife Temple Hills, MD 20746 7019 Tarquin Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Maryland National Cem 11-11-2011 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 ectarine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Thrombosis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ası IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 은 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 1911

Registrar DHMH 17 Rev 06-2011

State

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			Plea L State Registrar	State of M		d / Depa		t of H	lealth :		ental Hy		9	ible.	361	48	
	Physicia Medic		1. Decedent's Name (First, Middle Justo Lamber					_			2. Date of Dea		Ď11	Year	3. Time of D 5:30p	eath M	
	Examin		4a. Facility Name (If not institution, give street and number) Joseph Richie Hospice						4b. City, Town, or Location of Death Baltimore					4c. County of Death			
	Funeral Director		5. Social Security Number 062–32–6654	6. Sex 7. Ag	e (In yrs. la 79	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.		Date of Birth 9. Bir 11/26/1931			place (State or I htry) Hondu	ras	
aryland	a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County MD Anne A	rundel		, Town or Lo	cation								10d. Inside City		
with the M	23a or 28 ist be not	Funeral Director	10e. Street and Number 526 Realm Ct. I	East			10f. Zip	Code 1113				10g. C		What Cou	ntry?		
1036 rs after death	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	Ever in U.S No		Was Deced f Yes, spec			Cont	ify Yes or No- ican, etc.) ral/So ican	uth	Bla	ce - Americ ck, White,			
1215-0	ene. than "natu ne Medical	Completed		t's Education st grade completed) College (1-4 or :	5+)	16a. Dece (Give life. D Auto	kind of wo O NOT use	rk done a e retired)	luring mos	st of working	g		Kind of B	usiness/In	dustry		
<i>旨30中</i> か ' Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	lental Hygie rked other tic event, tl	To Be (17. Father's Name (First, Middle, L Justo Lambert			Auco	DOLLY	raii	18. Moth	er's Name a Mar i	(First, Middle, Lano						
Mary d2 should	alth and N 27 is ma er trauma		19a. Informant's Name/Relationsh Melissa Lamber		2						Route Numbe				Code)		
30pm more, Ma	nent of He ant: If iten Iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	3 ☐ Removal from State	20b. Pl	lace of Dispo emetery, crer Arunde	sition (Nar natory or c el Cr	ne of other place emate	ory 1	Da 11/12/	ate /2011			- City or T	own, State		
Balti Permit.	Departn Importa any inju	100	21. Signature of Funeral Service I	isgnsee	M014	52 Ba	Name ar Biley	Addres	eral	Home RD F	and Cr	ema	tion MD	_SVC	PA		
- Ph	ysician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause nly one cause on each lin	d the death e.	n. Do not ente	er the mod	e of dyin	g, such as	cardiac or	respiratory ar	rest,			Approximate interval Betwo	een eath	
~	Medical xaminer	L	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.														
w w point	ian and urial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as													
60 to alte be execute	0 0	dical E	resulting in death) Last	Due to (or as	a consequ	ence ory:											
Rox 68760	by the attending physi tached for use as the b	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Feta	Ideath 3	☐ Ectopic ☐ Other (sp		;y					ate of deliventh	,	∍ar	
S, P.O.	signed by d be detac		Part II. Other significant condition	ons contributing to death I	out not resu								o use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown				
$\mathcal{I}_{\mathcal{U}} \leq + \mathcal{O} \qquad \mathcal{L}_{\mathcal{A}}$ Division of Vital Records, P.O. I Hospital or Attending Physician: The law requires that the	cate has been si page 2 should l	Completed	24a. Was an autopsy prior to comperformed? 1 □ Yes 2 X No 1 □ Yes 2									ompletion of ca	vailable luse of				
US S Vital I	is certificate director, paç	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatie	nt 3 🗆 D	Oth		ath <i>(Check</i> Jursing Hon		dence	6 💢 Oth	ner (Specit	wHospic	CE_	
on of	death. stor: After thi y the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investig	g (Month, Da gation	1												
Division Atte	Solution Street and Number or Rural Rou Street and Number or R								al Route Numbe	er,							
he Hospit	iin 24 hours a he Funeral D	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best of xaminer: On the basis of Nurse Practitioner: To the	examination	and/or inves	tigation, in	my opinio	on, death o	occurred at	the time, date	and plac	ce, and di	ue to the c	ause(s) and man	ner stated	
To the	within 2 To the I comple		29b. Signature and title of certifier	dr	5		290		e number	71			ate signe	ed (Month,	. Day, Year)		
	10		30. Name and address of person R, ANANDA KI	CISHNAN	22	F W .	=u7	AW	57:	# 30	05 B #	+1-1	IM	ONE	MD2	120	
	Stat Registra		31. Date 180 Vor 1, 4 2011	Server 32. Registr	ar's Signat	and										,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 8 per fh e921 11-14-11 vt. State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) NOVEMBER 08 2011 Physician/ 08:50P M LEVINE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE REISTERSTOWN FUTURECARE CHERRYWOOD 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Numbe **Funeral** 219-18-2480 1 🗆 M 2 🖾 F **Director** $07/\frac{25}{1925}$ MD 86 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No BALTIMORE REISTERSTOWN MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21136 12020 REISTERSTOWN ROAD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. <u>Ş</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🖺 No If Yes, Give WHITE Completed 3 Nidowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME of Health and Mental Hygi item 27 is marked other other traumatic event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ ANN LEVY HYATT MAURICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALLSPICE COURT, OWINGS MILLS, MD 21117 FRANCINE RUSSELL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ō = 0 X Burial 2 Cremation 3 Removal from State Important: If any injury or 11/10/2011 REISTERSTOWN, MD OHEB SHALOM MEM.PARK 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Luna Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underly in Cause (Disease or injury Due to (or as a consequence of) use as the burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ Completed page 2 s Be

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death filled in by the 24 hours within 24 hou

To the Fune

completely fi

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Medical Certificate:

29b. Signature and title of certifier

NOV

				1 Yes 2 No 3 Probably 4 nknown						
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No						
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 Yes 2	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 🗆	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of Injury - At he building, etc. (Specif		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 Medical Exami	iner: On the basis of examination	n and/or investigation, i	n my opinion, death occurred	and due to the cause(s) and manner as stated. lat the time, date and place, and due to the cause(s) and manner stated place, and due to the cause(s) and manner as stated.						

Balhnere

29d. Date signed (Month, Day, Year)

21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Suite 203 Ruymord Mille 31. Date filed (Month, Day, Year)

State

Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Frank Lopez, Sr. 8:45 P. 10,2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Gilchrist Hospice Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Country Fairmont, Director 235-14-6333 1 **X** M 2 \square F March 08,1920 91 W.VA. (Marion Co) Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 Yes 2 No Maryland Parkville Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a Funeral 21234 2915 Topaz Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 1 Yes 2 No Guard If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. W.W. II 1 Yes 2 X No Specify: Specify. White 3 XWidowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the Electronics Inspector/Super. Electronics traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rose Mezzea Felica Lopez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parkton, Maryland 613 Coachmans Way (Son) Mr.Michael J.Lopez If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date C. Location - City or Town, State (Baltimore County) cemetery, crematory or other place) Tuesday ö 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Important If any injury or once. Moreland Memorcial Park Nov. 15, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 0.32.2. Name and Address of Facility

Peaceful Alternatives Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium Maryland 23a Oard 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final benc Physician/ onro Cos disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Disc to for as a honesquience of): cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? igned by the atte Yes 2 No 1 ☐ Yes 2 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ valvuler 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No has I or Attending Physician: The after death.

Director: After this certificate I funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 2 No hospice 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🔲 Yes 2 🔲 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending by the f Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [] 3 [] 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 11 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MUS 6701 N. C harles ST AARON M 31 Date filed (Month. Year) State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 1 Elinore Virginia Lent 2011 3:20 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore 3500 Croissant Road Parkville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🂢 F Hours Jan. 05, 1925 Baltimore, Maryland 86 **Director** 220-22-8740 Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore Maryland Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3500 Croissant Road 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Asian Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hyeru Tokunaga Ida Swenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 Croissant Road Parkville, Maryland 21234 Bonnie Miskimon (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State November 15, Loudon Park Cemetery 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility

Fyans Funeral Chapel & Cremetice

800 Harford Road Parkville,

a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility
Evans Funeral Chapel & Cremetion Services—Parkville
8800 Harford Road Parkville, Maryland 21234 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DEMENTIA A12HEINERS Sequer tially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Other (specify) Yes 2 XNo the 2 9 Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has but director, page 2 sh autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) After this s after death.
I Director: After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10# 1) 35 356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DEUNIS IT. COLE

NOV

31. Date filed (Month, Day, Year)

9106

32. Registrar's Signature

Ms 2-122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month 11:27 AM 2011 Physician/ Helen A. Malanowksi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** 217-12-8572 Director 1 M 2 XF Yrs Sept 6, 1922 Maryland 89 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21218 USA 2700 N. Charles Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc 2 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: white 'natural", 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Higene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Exconce. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) telephone company secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anna Reisch Karl Gruss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $527~{
m Hampton~Lane~Towson,~MD}~21286$ 19a. Informant's Name/Relationship (Type, Print) Linda Breidenbaugh/neice 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) e of Funeral Service State Anatomy Board 655 W. Baltimore Street MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and L ath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. resulting in death) Last Due to (or as a consequent burialphysician Medical Division of Vital Records, P.O. Box 68760 the as IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Por Day Pregnant at time of death Unknown ed by the a 9 Unknown ate has been signed by the page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. A q 2 M No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate I 2 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA ဂ္ 1 V Inpatient 2 this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred I Director: After the in by the funeral Certificate: 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2

To the I

comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of q 29c, License numbe Mallowe D>

Registrar
DHMH 17 Rev 06-2011

State

20 E UNIVERSITY PARKWAY BALTIMORE, MD21218

UNION MEMORIAL HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUTTAMED JASALEUC

31. Date filed (Month, Day, Year)

NOV

Baltimore, Maryland 21215-0036

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and	- H	Usual Residence of Deceder 10a. State 10b. C			10c. C	ity, Town or Lo	ocation			-				10d. Ins	ide City Limits
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 9:19 AM AUGHIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THROMA HUVENTIST WORTGOMEN 8. Date of Birth
(Month, Day, Year)
Nov. 5,193 Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Months Hours Country) Director 579-38-5359 77 DC Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Maryland P.G. Riverdale 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 20737 6810 Greenvale Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. δ 1 . Never Married 2 🙀 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. 1969 Specify.Black Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>rcondition Mechanic</u> <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lula Jenkins Neil McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rowenna McLaughlin Wife 6810 Greenvale Parkway, Riverdale. MD 20737 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Arlington Cemetery 12/22/11 Arlington, VA 22. Name and Address of Facility JB Jenkins Funeral Home 21. Signature of Funeral Service Licenses aphnel 7474 Landover Rd; Landover, MD 20785 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ditticile Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of the cont ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No of 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown detached Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Diseage Dialysis Dependent page 2 should be 1 Yes 2 No 3 Probably 4 Unknown vascular disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed death? 1 Yes 2 No rs after deau... ral Director. After this ceru... in by the funeral director, p? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **N**0 မ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 Doruch D68005 November 4th 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Camoli Avenue, Takona Park, MD 20912 Jennifer Obiadi, mD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

NOV 1 4 2011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) Physician/ 2011^{ear} 9:25 **1**₽ay November р Edmund B. Middleton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Arden Courts Towson 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept. 24 9. Birthplace (State or Foreign Country)
Rhode Island 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 036-20-7304 1 **X** M 2 □ F 89 **Director** 1922 Yrs Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location Director Maryland Baltimore Towson 1 🗌 Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21286 9 Aintree Road oe filed within ...
fental Hygiene.
arked other than "natural", or items
... event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 1943-1952 <u>6</u> Maryland 21215-0036 White 1 Yes 2 X No Specify. 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Medical Doctor 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medicine n and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname, Edna Mueller Nathaniel W. Middleton 19b. Mailing Address (Street and Number or Rural Route Number, City or 7 19a. Informant's Name/Relationship (Type, Print, 9 Aintree Road Mary Rebecca Middleton / Wife Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hill top Service Corporation 11/15/2011 Towson, Maryland 22. Name and Address of Facility Ruck towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Signature of Funeral Service License York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery ☐ Ectopic pregnancy jo Month 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown g 🗍 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Records, filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Fother (Specify) Asia Lad Liu 2 3400 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUTTE 4105 BALTIMORE MD KUMAR 6701 N CHARLES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ November 11, 2011 MARIE FLORENCE MILLER 4:45A Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Country) Director 133-09-8286 92 1 □ M 2 X X Yrs 06/24/1919 New York 28a-f show 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 XXYes 2 No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6304 Mayflower Road 21212 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify If Yes, Give Year or Dates Specify: 3 XXVidowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Saviano Sbordone Tomasina Casertano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Important: If item 27 is any injury or other trau 1037 Pinch Valley Road Westminster, Maryland 21158 Robert Preston Miller Son Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2XX Cremation 3 - Removal from State GreenMount Crematory Nov. 14,2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) gnature of Funeral S 22. Name and Address of Facility John 0 Mitchell IV Funeral Service of 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Dulaney Valley 200 E Padonia Road Timonium, Maryland 21093 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Donset and Death ne cause on the line. Immediate Cause (Final BKC Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy perforn 1 Yes Yes To the Hospital or Attending Physician: the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 1 Tes 4 □ Nursing Home 5 □ Residence Other (Specify) NOS P(CO 1 Inpatient 2 ER/Outpatient 3 IDOA s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work' Accident Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29d. Date signed (Month, Day, Year, November 11 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST Parison NAAVURI M 31. Date filed (Month, Day, Year, State 2011 1 4

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 27 per me, g921, 11/09/2011 dhb

Certificate of Death

Reg. No. for State Registrar 2. Date of Death dent's Name (First, Middle, Last 3. Time of Death O of cke Physician/ 2:04 PM 15 narlutte 201 Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) County of Dea **Examiner** Baltimure Wishington Medical Con Anne If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 07/21/1927 Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday, **Funeral** 1 □ M 2 👽 F Months Days Hours 204-22-0360 84 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director Anne Arundel MD Severn 1 Yes 2X No 10f. Zip Code 21144 10g. Citizen of What Country? 10e. Street and Number Funeral 8212 Whitebark Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Teaching Teacher 4yrs Be 17. Father's Name (First, Middle, Last)
Elwood Winfree 18. Mother's Name (First, Middle, Maiden Surname) Goldie Johnson ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8212 Whitebark Lane Severn MD 21144 Husband George Martin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crem 1 Burial 2X Cremation 3 Removal from State 10/17/11 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Signature of Funeral Service License ThomasAllenPA 7090 Ridge Rd Hanover MD nomy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final and Deau uche MEDINGTORY disease or condition Medical resulting in death) (or as a consequence o MUMUNIA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last ATTON APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Examiner

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

certificate

funeral

within 24 hours after death.

To the Funeral Director: After this

Completed by Be ပ Medical Certificate:

pnor to

2 🗌 No

5 Pendina

Investigation 6 Could not be

determined

25. Was case referred to medical

examiner?

27. Manner of Death

2 Accident

4 Homicide

Ivatural

Suicide

24a. Was an autopsy perforr

24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Gall at	
28f Location (Street	and Number or Rural Route Nu

Whythork Ln. Swarn, mo 2)144

29a.	Certifier	1 🖃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
	(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and
	only one) -	3 _ Cartifying Nurse practioner: To the past of my included a dath continued at the time, date and date, and die to the causele) and manner as stated.

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

prior to lotsell unknown

28b. Time of

29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) October 15, 2011 D0022483

28c. Injury at work? 1 ☐ Yes 2 ☐ No

30. Name and address of person leted cause of death (Item 23a) (Type, Print) 305 Hospital Dr. Glan Burne, MD 2106 MP

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

hospital

Hospital:

28a. Date of injury (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 6-35P M Noveyn by Frances Elizabeth Montgomery Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 01/03/1921 1 □ M 2 🗓 F Min Hours Director TAT 17 577-18-9094 90 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Tes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? event, the Medical Examiner must be Funeral items 23a 21144 7820 Elberta Drive U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ō 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 - Widowed 4 - Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Lumber Company 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ဂ္ William Programme 1 and Callaway Melinda Wycoff Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Philip Montgomery / Husband 7820 Elberto Drive Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 11/16/2011 Crownsville, MD MD Veterans Cemetery 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service License Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician nm disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown been signed by t should be detach P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Records, Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No the f Investigation Could not be after deatl Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours

To the Funeral Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) State Registrar

iantos Marcelino Villanueva Medirano 11-08438 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 9, 2011 2115 hrs Medical Examiner SANTOS MARCELINO VILLANUEVA **MEDRANO** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4400 Loch Raven Boulevard **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Hours Min. Months Days Director 1 X M 2 F N/A 25 01/16/1986 EÉ OUNS ALVADOR Usual Residence of Decedent Iny 10a, State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 Yes 2 No MD N/A BALTIMORE Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

aut. If item 27 is marked other than "natural", or items 23a or 28a-f sho not other trannatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7040 SURREY DRIVE APT. 21215 SALVADOR Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, 127 is marked other than "natural", or items umatic event, the Medical Examiner must be White, etc. 1 X Never Married Armed Forces? 2 Married 2 X No 1 Yes If Yes, Give Yeer 4 Divorced 1 X Yes 2 No specify: SALVADORAN Specify: WHITE Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 COOK RESTAURANT 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be CARLO MEDRANO ANGELICA PORTILLO MARIA ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OSCAR PORTILLO/ FRIEND 812 JUDY LANE, PIKESVILLE, MARYLAND 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State crematory or other place) EL SALVADOR 11/17/11 SESORI CEMETERIO SAN MIGUEL, 4 Donation 5 Other Specify: 21. Signature of Euneral Service Licensee 22. Name and Address of Facility LER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD 21231 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Shotgun Wound of Chest Immediate Cause (Final disease **£**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 1 Live birth 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 s performed? Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Division of Vital Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 Yes No 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject shot FOUND: Natural 1 Yes 2 ✔ No 5 Pending Nov 9, 2011 2110 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 4400 Loch Raven Boulevard , Baltimore , MD (Specify) Local Street 4 Momicide Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 10, 2011 llac 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Messner 2011 7:20 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facilify Name (If not institution, give street and number) Examiner Lorien Nursing Home Airy Carroll If Under 1 Year | If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours 1 □ M 2 🕱 F Months Days 81 12/19/1929 Director 214-28-0713 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County f show r 28a-f show notified at 1 ☐ Yes 2 X No Director MD Carroll Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with t annt of Health and Mental Hygione. ant: I flem 27 is marked other than "natural", or items 23a or 2 ury or other traumatic event, the Medical Examiner must be n. 21771 USA 713 Midway Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 점 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3₺Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Her Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Jeremiah Slagle Ella Mae Hess ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any Injury or other trau 7719 Harvest Hills Ct., Mt. Airy, MD 21771 Patti Cannaday/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 11/14/2011 Marriottsville, MD 21. Signatur of Funeral Service Licensee Burrier-Oueen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final diseas or condition resulting in death) Due to (or all a consequence of): Physician /Medical y can Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an page 2 s certificate 1⊟ Yes 2 No this certific ral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Injury 1 XX Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft To the Funeral D completely filled in Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

7112 Crobbury

29b. Signature and title of certific

32. Registrar's Signature back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Q

Ct, clarksville MD 21029

29c. License number

D0038578

29d. Date signed (Month, Day, Year)

DR. Bob

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30 per dyr g921 11-14-11 yt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08: 25 AM RUTH SHIRLEY MEYERS NOVEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF RALLIMORE BALTIMORE N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours 579-22-7273 1 □ M 2 🗓 F **Director** 86 09/18/1925 MD Usual Residence of Decedent 23a or 28a-f shov 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6004 BERKELEY AVENUE 21209 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d 2 should be filed with alth and Mental Hygien 27 is marked other th NURSE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 RICE JOSEPH **JENNY** SAPPERSTEIN 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st.
Department of Health an Important: If item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SONYA DAVIS / DAUGHTER 8035 CORNELL AVENUE, ST. LOUIS, MO 63130 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) LUBAWITZ NUSACH ARI 11/10/2011 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBELLAR HEMORPHAGE Medical Due to (or as a consequence of) Examiner 3 DAYS EMERGENU HYPER-TENSIVE Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or se a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): ttending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertention, Osteoarminitis, Osteoporons, Dynes gan, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronar Aprily Visease, eworzemal atrial fibrillation, 24a. Was an ate has page 2 s performed? Yes 2 No Moderninal 1 🗌 Yes antie ahewyon 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signati 29d. Date signed (Month, Day, Year) 1720372436 9 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital Ashrit Mulzani 31. Date filed (Month, Day 1 4 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 09^{Pay} Month 2011 Ralph Alfred MacMurray Jr. 6:10A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1012 Bennett Place N/A Baltimore Birthplace (State or Foreign Country) Social Security Number 215-40-9682 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) **Funeral** Days Min. Hours Director 1 🛛 M 2 🗆 F Yrs. 69 03/04/1942 Maryland Usual Residence of Deced 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or the content any injury or other trainment. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 X Yes 2 No MD N/A 10e. Street and Number 10f. Zin Code 10a, Citizen of What Country? 1012 Bennett Place 21223 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 2 1 Never Married 2 Married 1 Tes 2 No Specify: If Yes, Give Specify: Black 3 Widowed 4x Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ntary/Secondary (0-12) College (1-4 or 5+) Sanitation Baltimore City 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph A MacMurray Sr. Ruth Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leah MaCMurray(daughter) 1014 Bennett Place, Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Belleville Cem. 11/14/11 Suffolk, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Joseph Address of Brown Jr. Funeral Home PA MD21217 2140 N. Fulton Ave., Baltimore, illiam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ₽h, sician Due to r as a consequence of): disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown plnous Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 Director: After this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other 2 No Certificate: To 4 ☐ Nursing Home 5 Kesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1. Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after c

To the Funeral Direct

completely filled in by ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/10

Registrar

DHMH 17 Rev 06-2011

State

S. Greene St, Sqc16, Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 10, 2011 Physician/ 8:00 P M Nemerofsky Marie Therese Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Davs Hours 1 🗆 M 2 🛛 F France Director 138-26-4020 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2 😾 No New Jersev 0cean Whiting 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be 231 A Columbine Avenue U.S.A. 08759 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geiler Eugenia Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1269 Eureka Mill Run The Villages, Florida 32162 Alan G. Nemerofsky POA 20a. Method of Disposition
1 □ Burial 2 ★ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Hilltop Service Corp. 11-15-2011 Maryland 4 ☐ Donation 5 ☐ Other (Specify) Towson ture of Funeral Sen 22. Name and Address of Facility Ruck Towson Funeral Rome, Inc. Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes_2 No death? 1 Tyes 25, Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 1 No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

NOVEMBER

NEMEROFSKY

WARTE

32. Registar's Signature

2300 DULANEY VALLEY ROAD

21093

MD

TIMONIUM

CRNP

JUNECIA WHITE,

31. Date filed (Month, NOV 1 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year JOHN NAKAJIMA 0523 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death n/a UNIVERSITY OF MARYLAND MEDILAL COND BALTIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min. (Month, Day, Year) 35 205-62-1566 **Director** 1 X M 2 🗆 F Oct. 7, 1976 New York show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f 1 Yes 2 No MD Baltimore Lutherville 10e. Street and Number ò 10g. Citizen of What Country? must be i Funeral 104 Dublin Drive 21093 U.S.A. ural", or items? filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ρ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: Asian Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Electrical Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manager/Engineer Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Κ. Nakajima Martha Υ. Taira 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 104 Dublin Drive, <u>Katherine P. Nakajima-wife</u> Lutherville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greek Orthodox 11/15/11 Woodlawn, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BRAIN EDEMA disease or condition resulting in death) HERNIATION Medical Due to (or as a consequence of) **Examiner** walk-SUPERIOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury HUMTE LYMPHOBLASTIC LEUREMIA attending physician and for use as the burial-tran that initiated events resulting in death) Last ŭ Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death ed by the a Yes 2 No 9 Unknown g 🗌 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deal 28c. Injury at work? Certificate: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nr1: 118488321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE ST BALTIMORE , MD 21201 32. Registrar's Sig

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 20b per fh. 9921, 11/14/2011dhb
For Amend Item 27 per me, g921, 11/09/2011dhb
Registrar

Certificate of Death
Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Villian 110 IRVING /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ba 5. Social Security Number 6. Sex Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. Maryland 67 08/12/1944 Director 212-44-4024 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show Y Yes 2 No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21213 Funeral 3523 Juneway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Xi Yes 2 □ No
If Yes, Give Vietnam
Year or Dates: Era 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: δ 3 ☐ Widowed 4 K Divorced Era Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore permit. Pages 1 and 2 should be filed with Department of Health, and Mental Hyglens Important; if frem 27 is marked other the any injury or other traumatic event, I'm 1 0008. Public Maintenance Engineer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy A. Weska William I. Nutter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28 Stocksdale Avenue - Reisterstown, Maryland 21136 Danielle N. Moser (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Memorial Gardens
Oak Lawn Cemetery

10/07/2011 Baltimore, Maryland 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21087 11750 Belair Road - Kingsville, Maryland Xassah 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) hos **Physician** idosis /Medical Due to (or as a consequence of): Examiner ree Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDI Cohal Due to (or as a consequence of): burial Division of Vital Records, P.O. Box 68760 Physician/Medical attending p for use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by to be a detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ficate has been się r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral of 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural rending investigation Ortobe- 1,201 ((aknown 1E 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ∐Yes 2 No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 4 Homicide Down Dung 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number NP 1:1467784389 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEA: AF2664206587 5+1 me and address of person who completed cause of death (Item 23a) (Type, Print) 4940 . Registrar's Signature 31. Date filed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:50 AM November William Anthony Nori, Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harfor tizens Nursing Havre de Grac Home 8. Date of Birth (Month, Day, Year) 3 / 20 / 1923 9. Birthplace (State or Foreign Country) Maryland . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1**X** M 2 □ F Hours 216-12-6395 **Director** 88 Usual Residence of Decedent Fshow 10d. Inside City Limits 10a, State 10c. City, Town or Location at Director notified -28a-f Maryland Havre de Grace 1 X Yes 2 No Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö "natural", or items 23a o Funeral USA 21078 719 Chesapeake Dr. permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Black, White, etc 1 ☐ Yes 2 X No If Yes, Give δ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Fuel Station Owner Petroleum 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delores Dianuntis Alfred Nori 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Priscilla Forsythe/Daughter 877 Otsego St, Havre de Grace, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 9 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Erin Cemetery 11/15/2011 injury 4 ☐ Donation 5 ☐ Other (Specify) Mt. Havre de Grace 22. Name and Address of Facility
Tarring-Cargo Funeral Home,
333 S. Parke St. Aberdeen, M Signature F 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) his certificate has been signed by the adirector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Jiliam A 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work' 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who complete cause of death (Item 23a) (Type Signature

DHMH 17 Rev 7/2009

State Registrar Antonio Waverly Nock 11-07896 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 36168 2011 Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1552 hrs **Medical Examiner** October 20, 2011 Antonio Waverly Nock 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 2401 South Hanover Street Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) MD Days Hours Months Director 213-78-9839 1X M 2 F 52 07/09/1959 Usual Residence of Decedent 10d Inside City Limits 10a, State 10c. City, Town or Location iny 10b. County 1 Yes 2 X No MD N/A Baltimore 1 and 2 should be filed within 72 hours after death with the Maryland Health and Morntal Hygiene. Fleath and Morntal Hygiene file and 21 and 124 and 1 Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 513 N. Loudon Ave. 21229 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 X Yes Specify: Black 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12th Grade BCPS Truck Driver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Roy C. Young, Jr Margaret Nock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antolino Nock (brother) 513 N. Loudon Ave., Baltimore, MD 21229 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Itimore, 1 Sourial 2 X Cremation 3 Removal from State on site of cherolace tory 11/25/2012 Baltimore, MD Garrison Fores Owings Mills 4 Donation 5 Other Specify: 2705ephden FBrown Jr. Funeral Home 21 Signature of Funeral Service Licenses 2140 N.Fulton Ave., Baltimore, MD21217 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical K AMENDED 20a-c,23a,27,per FH,ME G925 3/21/12 TRT X UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Year 1 Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy icate has b performed death? ✓ Yes 2 No 2 No this certificate ✓ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA ို 1 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending 1 Yes 2 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide determined (Specify) 4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State
Registrar

OCME 2006

DHMH 17 Rev 1/2001

29c. License number

O.C.M.E.

OCME

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 21, 2011

and manner stated

e of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month NO

30. Name and address of person who completed cap

Theodore M. King, Jr., MD.

1 - State of Maryland / Department of Health and Mental Hygiene Per dr., g921, 12/14/2011 dhb Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Voor September 19, 2011 4:45 PM M <u>Felicite M. Putman</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Baltimore Genesis Brightwood Lutherville 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖸 F Months Director Maryland 219-20-9208 83 June 11, 1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or how many injury or other trainment. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2530 Mt. Carmel Road 21120 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ò Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n cook restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Gustave LeFaivre ပ Mary Katherine Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Harpole 3821 Beatty Road Monkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signaturi, of Funeral Service Li Rona Lo 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 □ No 2 🗆 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 21/10 Other: Certification: To 1 Tyes 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Mariner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tes 2 No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5677 November 8, 2011 30 Name and address of person who completed cause of death (ttem 23a) (Type, Print) botherulle mo Moral h, Day, Year) 142011 32. Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day INN 01:20 AM 201 AMES Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Em ner Battmore NIA Nursing ttane evindale If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 214.18.00 Months Davs (Month, Day, MID **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at **Funeral Director** Owinas 1 🗆 Yes 2 🔀 No Baltimore MD 10e. Street and Number 7ip Code 10g. Citizen of What Country? 5 23a 21117 Hollington Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 A Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ō þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Computer Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Ann 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 2117 19a. Informant's Name/Relationship (Type, Print) Pinn Drive 104. DWINGS MULLS MO Audres Hollington 20a. Method of Disposition 20c. Location - City or Toym, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2611 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) Green Funeral Services Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn Valles-C . Groce Road Pandallstown MD LIDEVITU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ NEUMONI disease or condition Medical resulting in death) Examiner HRONIC Sequentially list conditions. Physician/Medical Examiner If any, leading to minimediate cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMA! F: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2-1 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) n 24 hours after usaum ne Funeral Director. After thi maleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 10 SICIAN LEVINDALE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

51

S ASATUNDE 31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

2434

W. R

ELVEDERE

TIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Margaret Agnes Peyton November 9 20 T 3:32 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min. Director 8/14/1921 220-07-5253 90 Mary and Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 603 Harvest Court 21014 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry nd Mental Hygiene.
s marked other than "r
umatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Joseph Rennie Bertha Welsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>K</u>athleen M. Duley / Daughter 603 Harvest Court Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cem. 11/14/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 0 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, ement Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? ဂ္ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4-Nursing Home 5 Residence 6 Other (Specify, this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 MAHMOOD, TARIQ, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 4

NOVEMBER

PEYTON

WARGARET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** Ye ar Rachel Ann Pultz 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Franklin Square
5. Social Security Number 6. 1timore Hospital Rosed 8. Date of Birth (Month Day, Apr 27, **Funeral** 9. Birthplace (State or Foreign Months Days 1 □ M 2 🗓 F 1924 Kentucky 87 Director 407-22-1706 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼ No Director MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 1300 Windlass Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any Injury or other traumatic event, the Madical Example ponce. þ 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 registered nurse healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mollie Patrick Marvin Collins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1300 Windlass Middle River, MD 21220 19a. Informant's Name/Relationship (Type. Print) Gerald Pultz/spouse 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Sign ture of Euneral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer /Medical Due to (or as a consequence of): Examiner trial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed Hypertension

Due to (or as a consequence of): is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical Anemia 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 1 ☐ Yes 2 No 5 Other (specify) a∏IJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an eutopsy performed? 1 □Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law 1 ☐Yes 2 🗖 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

Dr. Scloastian
31. Date filed (Month, Day, Year

Year)

NOV 1 4

30. Name and

DHMH 17 Rev 1/2001

, 9000 Franklin

nistrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

D5517

29d. Date signed (Month, Day, Year)

November 6, 201

Square Drive Baltimore MD, 21237

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Physici	ian/	Registral	of Death	Reg. No. 2. Date of Death	3. Time of Death
al Exam				Month Day Yea November 1, 2011	
		4a. Facility Name (if not institution, give street and number) Northbound Rest Stop @ Route 95	4b. City, Town, or Location of Death Savage	4c. County o	f Death
Funeral Director			If Under 1 Year If Under 24Hrs Months Days Hours Min	(9. Birthplace (State or Foreign Country) Virginia
Maryland 28a-f show any d.at once.	٦	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 Yes 2 X No
ath with the Maryland items 23a or 28a-f sho ist be notified at once	Director		10f. Zip Code 20707	10g. Citizen of Wh	at Country?
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permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the McKal Examiner must be notified at once	Completed by	or Dates:	dent's Usual Occupation (Give kind of very most of working life. DO NOT use reti	vork done 16b. Kind of Bus	
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	h.	Robert B Baluff.	005 Pocohantas	Trail Willia	msburg, Va. 23
ysician Nedical aminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cal	er the mode of dying, such as cardiac or	respiratory arrest, shock, or hea	Approximate Interval Between Onset and
	: 11	or condition resulting in death) Due to (or as a consequence of):	diovascular Disease		Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	diovascular Disease		Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 6:45 AM ROGER 2011 PETERSON NOVEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months | Days 1**X** M 2 □ F West Virginia 213-52-4119 July 13,1949 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c City Town or Location show or 28a-f shown notified at 1 Yes 2 X No Director Dunda1k MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō death with ral", or items 23a or 21222 Winona Avenue 2-A United States Funeral permit. Pages 1 and 2 should be fled within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any injury or other traumment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 □ No If Yes, Give Year or Dates: Vietnam 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N.S.A. Machinist 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joyce Bunn Andrew F. Peterson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2-A Winona Ave. Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) 2-A Winona Ave. Dundalk, Maryland Mrs. Sharon M. Peterson(Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 11/12/2011 Baltimore, Maryland Oak Lawn Cemetery _5 ☐ Other (Specify) 4 Donation 21. Signature Ameral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the die complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fally List only one cause on each line. Immediate Cause (Final RESPIRATORY FAILURE HOURS **Physician** 4 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MYASTHENIA YEARS GRAVI Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached fi 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 TYes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 217 No 2 □ No 1 □ Ýes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No s after death.

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od in by the fu 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Funel completely fi Medical (check only one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 NOVEM BER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 LAURA TOCHEN MD 31. Date filed (Month, Day, Year) NOV 1 4 201 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Piorkowski Joan Rose Month 4:30 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2XX April Day Year 929 New Jersey 151-18-6333 82 **Director** Usual Residence of Decedent 28a-f shov 10a, State 10h County 10c. City, Town or Location with the Maryland Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Harford Bel Air 1 Tes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1418 Beacon Court 21015 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural". 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event; the <u>Me</u>dic once. 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Bookkeepper Gun & Book Club Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francesco Romamo Adelina Passalacqua 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Knoblauch/ Exector 1418 Beacon Court Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Evans Funeral th Chapel Nov. 4 ☐ Donation 5 ☐ Other (Specify) Bel Air |Forest Hill, Maryland Funeral Service Licenses 21. Signature Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Myo cordial disease or condition resulting in death) Medical **Examiner** NPUMONTO Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a gunsulculance of attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an autopsy perform Yes 2 No Vital Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifyin, Nurse Practioner: To the best of my knowledge doubt on 29b. Signature and title of 29d. Date signed (Month, Day, Year) November 3, 2011 D63653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER Chesapeaka Drive Bel AIR, MD 21014 State Registrar

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 X Other (Spec	Removal from State		y, crema	tion (Name of tory or other place Cemete		Date 1-15-11			- City or Tov	· ·			
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To the To the comp	-	29b. Signature and title of certifier	L	<u>:</u>		29c License			_		d (Month, E				

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAUN J WAVEL W JOIN NOV 1 4 2011

ARRIVATOR OF THE PRINT OF TH

29c License number 5833

Chirles ST rowson mo

29d. Date signed (Month, Day, Year)
November 10 70 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 I ar 9:30 AM M November Ruth Ann Robbins Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 137 Day Coach Circle Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthdav. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🛛 Months Days Hours (Month Day, Year) pr 13, 1939 72 Maryland Director Apr 213-36-5119 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Tes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral with 1 23a 137 Day Coach Circle 21220 IISA items Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education unk unk 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Robert Rittenour Myrtle Virginia Flook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Duke of York Lane #3 Cockeysville, MD 21030 Teresa Zotos/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Funeral Service Licensee Ronal d S State Anatomy Board 655 W. Baltimore Street 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ CAncer -Ma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical death certificate be P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Day 5 Other (specify) Month Year Pregnant at time of death signed by the a d be detached for 1 ☐ Yes 2 년 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 certificate has 25. Was case referred to medical examiner?

1
Yes

2
No Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this сотрете filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No death. 2 Accident Investigation 24 hours after deat Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) ρ

State Registrar 30. Name and

NOV 1

6701 N. Charles St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7.18 AM Physician/ R195B> EDWARD Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltonne Karson Common | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar 0 1948 9. Birthplace (State or Foreign 7. Age (In yrs. last/birthday) **Funeral** Months Kentucky 1 🕅 M 2 🗆 F 214-50-2614 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f shov 10a. State 10b. County Director 1 Yes 2 No Sykesville Carrol1 MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21784 7425 Village Road #2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 168-70 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) welding self employed unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martene Higdon James Rigsby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Slingshot Lane Gerrardstown, WV 25420 Ricky Rigsby/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🗖 Other (Specify) in state Stare and Ardress of Facility and 655 W. Baltimore Street Sig ature of Funeral Service Licenses Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown within 24 hours after death.

To the Funeral Director. After this certificate has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be 2 **W**No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier

State Registrar Bult

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{rea} 9:30 AM M November <u>Patricia M. Rote</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Forest Hill 505 Forest Valley Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number '. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 232-70-0364 Director 1 🗆 M 2 🖫 F West Virginia 66 May 28, 1945 Usual Residence of Decedent 28a-f show 10d. Inside City Limits with the Maryland at 10a. State 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Forest Hill Harford MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21050 505 Forest Valley Drive 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) math teacher education 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be 1. Department of Health and Mental. Important: If item 27 is more any injury or othor-2 Jeannette Elizabeth Stingo David Mainella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Forest Valley Drive Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type, Print) Stanley Rote/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) ral Servi rector State Anatomy Board 655 W. Baltimore Street Sens Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between mulliple Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
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To the Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 D No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 Tyes 2 No Accident Investigation completely filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 9277 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mon

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 20 PM Loretta C. Rosenberger 101 201 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNIFL HOCPITAL LTIMORF Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 🗆 M 2 🕱 F 06-05-1923 220-18-2719 Director 88 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 919 Calwell Road 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. <u>\$</u> 1 Never Married 2 Married 1 Yes : 2X XNo Maryland 21215-0036 1 Yes 2x No Specify: 3 ☒ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Susan Matthews Charles Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan P. Koment - daughter 1890 Woodstock Road, Woodstock, MD 21163 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖾 Other (Specifentombment Meadowridge Mem Park 11-15-2011 Elkridge, MD 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Signature MMP, Inc. 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical LOR attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Other (specify) Pregnant 1 Yes 2 9 Pregnant at time of death s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner?
1

No

Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending injury Division 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hikas D72450 NOV. 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 900 (ATON AVENUE, BALTIMORE, MD-21229 DHOT

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER Day 4 2011 Physician/ \mathbf{P}^{M} 6:48 MAE ROSS BERTHA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours JULY 30 1920 NORTH CAROLINA 244-22-8840 91 Director 1 🗆 M 2 🗓 F Yrs Usual Residence of Deceden 10d Inside City Limits 28a-f show 10b. Count 10c. City, Town or Location ms 23a or 28a-f shormust be notified at 10a. State within 72 hours after death with the Maryland Director Yes 2 No MD PRINCE GEORGE'S DISTRICT HEIGHTS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 7500 KIPLING PARKWAY 20747 or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural" Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE 7th HOUSEWIFE permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည **BERTHA** MAE BRISTOW JOHN HENRY FREEMAN 20747 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7500 KIPLING PARKWAY DISTRICT HEIGHTS, MARYLAND JUDY ROSS/DGT. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/18/2011 | LANDOVER, MARYLAND HARMONY CEMETERY 4 Donation 5 Other (Specify) J.B. JENKINS FUNERAL HOME, INC. . Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Friter the gisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate cause (First Approximate Interval Between Onset and Death Ph_sician/ a CARDIORESPIRATORY ARREST disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** HYPERTENSIVE CARDIOVASCULAR DISEASE quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed AORTIC STENOSIS -tran and Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Vear Month Pregnant at time of death 5 Other (specify) g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 death? Yes 2 Will 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 I DOA မ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After 5 Pending work? 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 8, 201 027650

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Registrar

DHMH 17 Rev 06-2011

State

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OXON HILL RD #500 OXON HILL, MD 20745

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLEEN

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wilbur Thomas November 2011 5:16 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 11140 Green Valley Rd. Union Bridge Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Jun. 10, **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 □ F Director 67 215-44-1721 Jun. Maryland Usual Residence of Decedent fshow te the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Frederick Union Bridge 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 11140 Green Valley Rd. 21791 U.S.A. should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 11 maintenance town government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o မ item 27 is marke other traumatic Wilbur E. Reese, Sr. Elizabeth Bollinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) i Health Fay F. Reese/ wife 11140 Green Valley Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State tof :=: cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 11/11/2011 Mountain View Cem. Union Bridge, MD multe of Pheral Service Licens 22. Name and Address of Facility Hartzler Funeral Home E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancar LIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year Yes 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy , page performed? death? the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 10 1 Tyes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 10 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address

31. Date filed (Month, Day, Year)

Gene

10200 Coppermine Rd.

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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D31058

Woodsboro, MD 21798

SCHOPP, RALPH D.

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Records
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		_	Registrar 1. Decedent's Name (First, Middle, Last)			Certificate of E	peatn	Reg.		3. Time of Death
	Physicia Medic	cal	RACPH SCHOPP 4a. Facility Name (if not institution, give si	and and my make it		1 0 T	Nanation of Darkh	OCTOBER	30 2011	11:34 6 W
	Examir Funeral		BALTIMORE WASHINGT 5. Social Security Number 6. Sex	ON MEDICA	L CENTE	e G	LEN BUR If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir	RUNDE L
4	Director		390-60-3675 1 National Residence of Decedent]M 2 □ F	58 Yrs	S. Months Days	Trodis Witt.	Aug 26,	1953 18	ulisana
	ryland -f shov ied at	Director	10a. State 10b. County		0c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	the Ma or 28a e notif		MD Anne Aru 10e. Street and Number	ndel		Glen Burni	e	10g.	Citizen of What Co	
	th with ns 23a must b	Funeral	301 Juneberry Way				061		USA	
036	s after deal ral", or iter Examiner	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	2. Was Decedent Eve Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.	r in U.S. 39–93	13. Was Decedent of Hill If Yes, specify Cuba1 ☐ Yes 2 X No		cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: wh	e, etc.
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Manyland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)	cation e co <i>mpleted)</i> College (1-4 or 5+)	16a. De	ecedent's Usual Occup- tive kind of work done of e. DO NOT use retired)		ng 16k	b. Kind of Business	
d 22	ed with Hygier other t	l ou l	12 17. Father's Name (First, Middle, Last)	2		teacher	18 Mother's Name	e (First, Middle, Maid	educatio)II
ylan	d be fill Mental arked c	욘	Ralph Schopp					Dettmer	on comainey	
Man	2 shoul Ith and I 27 is ma trauma		19a. Informant's Name/Relationship (Type Cara Martin/siste		19b. M 534	Mailing Address (Street a	and Number or Rura eet Racin	Route Number, City e , WI 53	y or Town, State, Zij 402	o Code)
more,	Page 1 and ment of Hea ant: If item ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)			isposition (Name of crematory or other plac		Date 200	c. Location - City or	Town, State
Balti	permit. Page Department of Important: If any injury or once.		21. Sign rup of Funeral Sept le License	1/1/2	tor	State and Address Baltimore,			altimore	Street
Pinga MC	Physician/ Medical Examiner ial-transit	Examiner	shock, or meart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of): onsequence of):					Interval Between Onset and Death
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	pregnancy Fetal death me of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _			23d. Date of de Month	Day Year
ν, σ.	res tha signed d be de	þ	Part II. Other significant conditions con	tributing to death but	not resulting in t	ne underlying cause giv	en in Part I.			orthe cause of death?
Division of Vital Records,	sician: The law require certificate has been si rector, page 2 should	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Ta Ta	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?	nonital:			ace of Death (Check		3 110]	
<u> </u>	Physic this or	٠ <u>.</u>	1 ☐ Yes 2 🔀 No	ospital: 1 Nation1 28a. Date of injury	2 ER/Outp	atient 3 DOA Other	4 L Nursing Ho	me 5 Residence		cify)
ouo	ending sath. ir: After	ficate	1 Natural 5 Pending Investigation	(Month, Day, Y		ry work		Edg. Describe now ii	njary occurred	
INISI	Il or Attending s after death. I Director: After d in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (, street, factory, office		28f. Location (Street City or Town, Si		ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death and the Funeral Director. After this certific completed filled in by the funeral director,	Medical		er: On the basis of exar	nination and/or in		on, death occurred at	the time, date and p	lace, and due to the	cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	A		29c. License			Date signed (Mont	
			30. Name and address of person who co		th (Item 23a) (Typ		3314	00	CTOBER 30	3 2011
			CUILLERMO DOSE 6	AHERECO	301 HO	SPITAL DRI	WE, CLE	N BURNIC	E, MD 2	0/6/
	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV 1 4 20	32. Fegistrar's	Signature	backet				
	AH 17 Pay 7/2			1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) October 24, 2011 2:25 PM M Physician/ Paul Raymond Schultheis Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Carroll 404 Mathias Court Unit E Westminster Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) **Funeral** Days 1**X**□ M 2 □ F **Director** 218-46-0400 Oct 23, 1945 Maryland 66 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2X No Westminster Carroll MD 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21157 404 Mathias Court Unit E death \ 14. Race - American Indian, Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 📈 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after white 1 ☐ Yes 2 🕅 No Specify "natural", 3 Widowed 4 X Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatio. Elementary/Secondary (0-12) College (1-4 or 5+) Lowes/plumbing 0 salesperson 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Kathrine Weidefeld Paul Raymond Schultheis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3284 Elmmeade Road Ellicott City, MD Mary Gallagher/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (SA StatendAddatoMyoliBoard 655 W. Baltimroe Street Signatu **Virector** 21201 Baltimore, MD nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner com Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami use as the burial-transi UGSC that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical OKIN that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ί 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Il or Attending Physician: The law requires that death.

Director: After this certificate has been sign Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 10 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 27. Manner of Death 28c. Injury at Natural injury 5 Pending 1 Yes 2 No Investigation Accident filled in by the 6 🗆 Suicide Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The basis of examiner: On the basis of examiners and of involutions, many spanish, many spanish, and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 36796 pleted cause of death (Item 23a) (Type, Print) 1838 Greentier Rd MU mmin9 State 1

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 18,19a per fh g921 11-16-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:58 PM NOVEMBER 2011 STRINGFELLOW THOMAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S BOWIE BOWIE HEALTH CENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 577-38-7757 1 **X** M 2 □ F Yrs PRINCE GEORGES JULY 29 1919 92 28a-f shov 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Examiner must be notified at Director 1x Yes 2 No PRINCE GEORGE'S BOWIE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral items 23a USA 20715 3850 ENFIELD CHASE COURT #316 Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No ARMY Black, White, etc. ò þ 1 Never Married 2X Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: BLACK "natural" 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT 12th CHAUFFEUR Be 18. Mother's Name (First, Middle Maiden Surpaum, VTOT.A D. STREINGTELLOW 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thent of Health and Mental Health then 27 is marked ot မ UNKNOWN 19a **CATHER FOR T**Relationship (Type, Print)

KATHERINE STRINGFELLOW/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3850 ENFIELD CHASE COURT #316 BOWIE, MARYLAND 20715 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition t of cemetery, crematory or other place) 1 X Burial ation 3 - Removal from State Department of Important: If any injury or 11/18/2011 CHELTENHAM, MARYLAND Jonation 5 Other (Specify) MD VETERANS CEMETERY Signature f Funeral Se 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. ce Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 he that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part 1. Enter the disease, or complical snock, or heart failure. List only one complical Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year in the past 12 months? Month Dav f Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Records, Completed neec 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 performed? 1 ☐ Yes 2 ☐ No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🔀 No Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Bowie Health မ completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 11, 2011 D68418 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER ALAN PASH M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav10 Month Physician/ Mary C. Sapienza November 2011 22:00 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. Sunrise of Severna Park Severna Park 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral Country) Nebraska (Month, Day, Year) 11/06/1915 Hours 1 □ M 2 👿 F 96 Yrs. **Director** 506-14-5380 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other **** 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County Director 1 Yes 2 No MD Anne Arundel Co. Severna Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 50 West Jones Station Road 21146 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X☐ No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department College (1-4 or 5+) Elementary/Seconday (0-12) of Motor Vehicles 12 Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Filadelfo Catania Concetta Castiglia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Severna Park, MD 21146 50 West Jones Station Road Mrs. Concetta I. Mangold/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park : 11/18/2011 4 Donation 5 Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License M01121 Services PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Vaccular Decemparation Approximate Interval Between Vascular Degeneration Onset and Death Immediate Cause (Final Physician/ 12herrer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine up to for as a punsuouence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the at d be detached for Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 \ No ည within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier NOVEMBER 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) millersville md 21108 860, Veterans Hwy State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 5:05 P M November Twigg Janet Hering Stottlemyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick St. Catherine's Nursing Center Emmitsburg Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun. 17, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Maryland 1 M 2 X F Months Hours Min 82 214-28-0853 **Director** 1929 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director 1 Tes 2 X No Pennsylvania Franklin Fayetteville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō event, the Medical Examiner must be Funeral 23a U.S.A. 17222 11302 South Mountain Road items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ traumatic Francis Hering Margaret Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thurmont, MD 21788 Daniel Twigg/ son 13712 Catoctin Furnace Rd. Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/11/2011 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Sykesville, MD 21, Six the of Juneral Service Ligen 22. Name and Address of Facility Hartzler Funeral Home att Jarias Box 249 New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between set and Death shock, or heart failure. List only one cause or Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as nsequence of) Examiner Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Pregnant at time of death 9 Unknown been signed by the sahould be detached 9 Unknow contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 XNo 3 Probably 4 Unknown 1 \square Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has b. autopsy page 2 death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, . Was cas referred to redical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 X No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature

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32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

arrol

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Ave

Emmitsburg

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Day Physician/ Nov. 2011 11:50AM Philip Sorbera Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA 1202 Frailey Way Baltimore Birthplace (State or Foreign Country)
 PA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Hours (Month, Day, Year) 1 80 188-22-7674 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at with the Maryland Director XXYes 2 No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a USA 21205 1202 Frailey Way within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. à 1X Never Married 2 Married "natural", or Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Caucasian Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Warehouse aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mitchell bei Charles Sorbera Genevieve permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic or 19a. Informant's Name/Relationship (Type, Print) Daughte, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21221 Christina Thompson Hartman Avenue Essex, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville 11-15-11 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. Street Baltimore, MD 21217 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ovonavy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for se a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perfor 1 ☐ Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 Residence 6 \(\sum \) Other (Specify) 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 1202 Fran Ey Way Buy Mp 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 |

		1	State Registrar			Cert	tificate of E	Death		Reg. No.			
			1. Decedent's Name (First, Middle, Las	t)					2. Date of De		Year	3. Time of Death	
Physi Me	ician edica		WALLACE F.	SMITH	JR				Month 11	11/2	011	22:42 P.M	
	mine	-	4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or	Location of De	ath	4c. Coun	ty of Death	1	
.			GOOD SAMARITA	N HOSPI	TAL		BALTIM		MD	N/A			
Fune Direct	_	.5	5. Social Security Number 6. Se 219–28–0815		i (In yrs. lasi 78	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	th 20, 1932	g. Birth	nplace (State or Foreign htry) /land		
yland •f show ed at		1010	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City,	Town or Loc Baltin						10d. Inside City Limits 1 → Yes 2 □ No	
the Mar a or 28a be notifi		≝L	10e. Street and Number				10f. Zip Code 2121	1		10g. Citizen o			
hwith			2605 Roselawn Avenue										
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The 27 is marked other than "natural", or items 23a or 28a-f show offer traumatic event, the Medical Examiner must be notified at		2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 2 Yes 2 If Yes, Give Year or Dates.		roa lf	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🏖 No	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
15-0 72 hour In "natur Medical		Completed	15. Decedent's Ec (Specify only highest gra	de completed)		(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during most of v	16b. Kind of	Business/I	ndustry		
vithin vithin jiene.			Elementary/Secondary (0-12)	College (1-4 or 5	+)	Supervi	sor	_		Dairy Co	mpany		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 2 ris marked other than "natural", cr traumatic event, the Medical Exam		lo De	17. Father's Name (First, Middle, Last) Wallace F. Smith, Sr.			·			Name (First, Middle, C. Doody	Maiden Sumai	n Surname)		
e, Maryl and 2 should I Health and Mc tem 27 is mar ther traumati			19a. Informant's Name/Relationship (Ty Marianne Clark/ Daugh			19b. Mailin	g Address (Street a	and Number or vn Avenue	Rural Route Numbe Baltimore	er, City or Town, Maryland	State, Zip 1 212	Code) 14	
of Her		12	20a. Method of Disposition	Danie avel from Chata			sition (Name of atory or other place	ce)	Date	20c. Location	-		
Page 1 ment of ant; If it			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 💢 Other (Specif	Entombrent		ens of l		1	1/16/11	Bal [.]	timore	Maryland	
Baltimore, permit. Page 1 and Department of Heal Important: If item;	once,		21. Signature of Funeral Service Licens	00_		12g 5.	Sonard 5ddre 305 Harford	Ruck; Inc I Road B	altimore Ma	ryland 2	21214		
		7	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused	the death.	Do not ente	r the mode of dyin	g, such as card	iac or respiratory a	rrest,		Approximate Interval Between	
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Medic Examir	_		resulting in death)										
	-	5	Sequentially list conditions,	b. HYPER								YEARS	
ed			if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	aconseque	rice oi).							
kecuti n and al-trar		LYG	that initiated events resulting in death) Last	C. Due to (or as a	a conseque	nce of):			-				
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68760 ertificate b ding physise as the l		2		u									
Division of Vital Records, P.O. Box 68760 tal or Attending Physician; The law requires that the death certificate be executed rs after death. al Director. After this certificate has been signed by the attending physician and al pirector. Agree this certificate has been signed by the attending physician and eld in by the furneal director, page 2 should be detached for use as the burlansit			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 🗀	Ectopic pregnand Other (specify)	су			Date of del Month	ivery Day Year	
hat the ed by detac	Ž		Part II. Other significant conditions co	ontributing to death b	ut not resul	ting in the ur	nderlying cause gi	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?	
S, F irres the signal ld be		ה ה	HYPERTENSION	V. DYSL	IPID	EMIP	CORO	NARY	_ 1_	Yes 2 □ No	3 🗆 Pi	robably 4 🗆 Unknown	
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Vita /sicia s cert direct	15	0 DE	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 E	R/Outpatien	t 3 DOA Oth	er.	g Home 5 🗆 Res	idence 6 🗆 0	ther (Spec	ify)	
of g Phy er thi			27. Manner of Death	28a. Date of inju	ry 2	28b. Time of injury	28c. Injur work	y at		how injury occi			
on andin ath. r: Aft		2	1 Natural 5 Pending 2 Accident Investigation		,, , , , ,		M 1 🗆	Yes 2 No					
r Atter de irecte		Ceruncate	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju		ne, farm, stre	et, factory, office			(Street and Nur wn, State)	nber or Rui	ral Route Number,	
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director,		Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	sician: To the best of ner: On the basis of e se Practitioner: To th	xamination :	and/or invest	igation, in my opini death occurred at	on, death occurr the time, date ar	red at the time, date	and place, and the cause(s) an	due to the o d manner a	cause(s) and manner stated as stated.	
Norith Com			29b. Signature and title of certifier	4. 2			29c. Licens			29d. Date sig			
			1 July .	M·D			RES			11/1:	1/20	011	
4)			30. Name and address of person who of SRITIKA THE	IAPA, B	ALTI	MORE	rint)	560 212	1 Loch Rave 39	en Blvd.			
	State istra		31. Date filed (Month, Day, Year) NOV 1 4 2011	32. Registra	ar's Signatu	arks							

OHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:05 PM 2011 VOUE MBER LLOYD STEWART Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT JOSEPH MEDICAL CENTUR OWSON Birthplace (State or Foreign Country) 6 Sex Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. (Month. Day, Year) Hours 196-12-9169 Director 1**X** M 2 □ F 07/04/1926 PA 85 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 X No BALTIMORE CATONSVILLE 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 715 MAIDEN CHOICE LANE, #307 21228 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Examiner Black, White, etc. ō ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural", 3 Widowed 4X Divorced WHITE Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ PSYCHOLOGIST MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If item 27 is marked o any injury or other traumatic eve ဂ Page 1 and 2 should be SCHWARTZ LOUIS MIRIAM L 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID SCHWARTZ/SON 646 REGESTER AVENUE, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/11/2011 4 Donation 5 Other (Specify) OHEB SHALOM MEM PK REISTERSTOWN, MD Signature of Funeral Se 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Eigher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final LOSS BLOOD ANEMIA Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SASTROINTESTINAL BLEEDING 3 DAYS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical as the t IF FEMALE ise s yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director; After this certificate has been sign DELIRIUM 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, s certificate has been sidirector, page 2 should b SPHAGIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🕱 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral a 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d Describe how injury occurred 1 X Natural iniury 5 Pending □ Accident Investigation 6 Could not be Place-of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar DHMH 17 Rev 06-2011

State

29b. Signature au

30. Name and address of person wh

(Month, Day, Year) V 1 4 2011

MICHAEL J. MININSOHN,

7601 OSLER DRIVE

TOWSON, MARYLAND 21204

eted cause of death (Item 23a) (Type, Print)

32. Registra s Signature

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / [giene		
			State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Dea	th 2. Date of De	Reg. No. 20	3.5 9 3. Time of Death	
	Physicia		Edith Svenson			r 1 ^{Day} , 2011	1:32 AM M	
No.	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loca		4c. County of Death		
المعيدة			Smith Creek Assisted Living	Warwic		h g. Birthplace (State or Foreign		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		ours Min. (Month, Da	ay, Year) Cour		
	d ow		Usual Residence of Decedent 100 10a. State 10b. County 10c. City, Town		Aug 14	, -,	10d. Inside City Limits	
	arylan a-f sh fied a	Director					1 ☐ Yes 2 ▼ No	
	the M or 28 e noti		MD Cecil W 10e. Street and Number	arwick 10f. Zip Code		10g. Citizen of What Cou	ntry?	
	h with	Funeral	88 Welders Lane		21912	USA		
10	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 汉 No	13. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	Black, White,	etc.	
21215-0036	rs afte ural", o		3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Sp	pecify:	Specify: Whi	te	
15-0	72 hou n "natu ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during life, DO NOT use retired)	most of working	16b. Kind of Business/Ir	ndustry	
212	vithin liene. er thar the M		Elementary/Secondary (0-12) College (1-4 or 5+)	silversmith		jewel	ry	
nd	filed v al Hyg d othe		17. Father's Name (First, Middle, Last)	18.	Mother's Name (First, Middle			
ryla	should be and Ments is marked raumatic e	J D	Francis Thomas Eigner 19a. Informant's Name/Relationship (Type, Print) 19b.		Ethel Genev		Cada	
Ma	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hyglene. It heath and Mental Hyglene item "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Sandra Bachman/daughter	Mailing Address (Street and No. 3 Forrest Lane	e Chesapeake	City, MD 21	915	
Baltimore, Maryland	age 1 and 2 sent of Health nt: If item 27 y or other tra			f Disposition (Name of ry, crematory or other place)	Date	20c. Location - City or T	own, State	
Baltir	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Sign re of Euneral Service Licensee		Facility Board 655	W. Baltimore	Street	
	_		23a. Part Enter the disease, or complications that caused the death. Do r shock, a heart failure. List only one cause on each line.	Baltimore, not enter the mode of dying, such	mD 21201 ch as cardiac or respiratory a	rrest,	Approximate Interval Between	
	hysician/		Immediate Cause (Final disease or condition	Artery Dis	ease		Onset and Death	
Same of the same o	Medical Examiner		resulting in death) Due to (or as a consequence of	of):			·	
		ner	Sequentially list conditions, If only leading to immediate Due to lor as a consequence of	of):				
	outed nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
	te be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of	of):				
260	icate by physics the l	ledic	d					
Box 68760	n certifi ending r use a	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 1	a 3 ☐ Ectopic pregnancy		23d. Date of deli		
	ss that the death certificat igned by the attending ph be detached for use as th	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	5 Other (specify)		Month	Day Year	
P.0	that the	by Pr	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in		tobacco use contribute to	_	
ds,	requires been sig should b	ted			1 🗆	Yes 2 No 3 Pro		
Division of Vital Records, P.O.	sician: The law requires that the death certifical certificate has been signed by the attending princetor, page 2 should be detached for use as the	Completed			perf	opsy prior to c formed? death?	opsy findings available ompletion of cause of	
tal	cian: 1 ertifica ector, p	Be	25. Was case referred to medical examiner?		of Death (Check only one)	•		
f Vi	Physi this o	2	1 Yes 2 No 1 Inpatient 2 ER/Ou	stpatient 3 DOA Other: 4 Fime of 28c, Injury at	Nursing Home 5 Res	idence 6 Other (Special how injury occurred	fy)	
ouc	ttending I death. stor: After y the funer	icate	1 Natural 5 Pending (Month, Day, Year) i 2 Accident Investigation	njury work? M 1 ☐ Yes	_			
)ivisi	I or Atten	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		(Street and Number or Run wn, State)	al Route Number,	
_	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/conly one) 3 Certifying Nurse Practitioner: To the best of my knowledge,	or investigation, in my opinion, de	eath occurred at the time, date	and place, and due to the c	ause(s) and manner stated.	
	To the vithing to the company of the	_	29b. Signature and title of centier	29c. License num	nber	29d. Date signed (Month)	, Day, Year)	
			Sachders MD	0008	93322 Elkten MD 2	11.4.	2011.	
			30. Name and address of person who completed cause of death (Item 23a) (\$\int \cdot	High St, E	Electen MD 2	494.		
Ì	Sta Registr		31. Date filed (Month, Day, Year) 32, legistrar's Signature NOV 1 4 2011	Sarke				
	51041		I Johnson					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Deborah Ann Sullivan 20 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital N/A Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** NOV . 21 Months Hours Min. 518-86-5773 7961 Director 1 □ M 2 🕱 F 49 Yrs California 28a-f show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2606 Roselawn Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces?

1

1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by white 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Nursing Home Elementary/Secondary (0-12) Nurse Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Marian Irene Clifford Richard Bertirum Livingstone should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21214 19a. Informant's Name/Relationship (Type, Print) 2606 Roselawn Avenue-Baltimore, Maryland Harry Caton, Jr-spouse timore, 20a Method of Disposition 20c. Location - City or Town, State 20b Place of Disposition (Name of Fvanser Funeral on Ser. belair Nov. 10, 2011 Forest Hill, Maryland Page 1 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Fundadiss Claret and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 andri LM Ford 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transi and that initiated events resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform To the Hospital or Attending Physician: The lowithin 24 hours after death.

To the Funeral Director: After this certificate he completely filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to nedical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann - of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Perflying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 32. Registrar's State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9^{Day} Month Physician/ Schueler 2011 Mary 8:20 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford County Forest Hill 315 WillrichCircle, Apt. F. 9. Birthplace (State or Foreign Permsylvania 8. Date of Birth

Jan 1. Day, Year) 920 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2**X**) F Months 91 121-12-0500 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he motified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Maryland 1 Yes 2 No Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 315 Willrich Circle Apt. F 21050 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ✗ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Ethel Lindsley Father's Name (First, Middle, Last) Loren M. Gigee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16066 Kline Young Rd. Stewartstown, PA Robin Wigley / Daughter 20a. Method of Disposition 20c. Location - City or Town, State Evans Funeral Mapel 11/10/2011 1 Burial XX Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Juneral Service Licensee 22. Name and Address of Facility Evans Funeral CHapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 pa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physiciani Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Yac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated sease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death n signed by the and to be detached for Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown accident, Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? Aortic stenosis osteoporosis 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical

n 24 hours after death. • Funeral Director: After this certificate has been within 2 To the I

> State Registrar

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Naauin

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Colgate

gistrar's Signature

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

URIVE, SUITE 103 FOREST HILL, MD 20050

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:30 P. Edith Mabel 2011 Medical Shook November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Jan. Day, Days Hours Year 929 Mary Tand **Director** 82 426–64–8130 Usual Residence of Decedent 1 M 2X F ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Maryland Harford White Hall 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4240 Harford Creamery Road 21161 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give i "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify.White 3 Widowed 4 Divorced Completed Year or Dates I and 2 should be filed within 72 hourn f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Payroll Administrator Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Abram H. Wood Eliza Frances Hash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Shook / Son 2843 Troyer Road White Hall, MAryland 21161 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot Noverte 16, Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gardens 4 Donation 5 Other (Specify) Fallston, Maryland 2011 uneral Service 21. Signature Evans Funeral Chapel & Cremation Service—BelAir sau 3 Newport Drive Forest Hill, Maryland 21050 23a, Part 1, Enter the disease, or compl is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last ng physician and as the burial-tran Due to (or as a consequence of): the attending physician the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 A No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 3 N 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Normer (Specify 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature ar 29d. Date signed (Month, Day, Year, 29c. License number 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUTTE 4105 RALTINORE 107 NCHARIES 37 State 1 4 201 NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene

Reg. No.

Reg. No. 36195 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Novembe James William Shaffer ,20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Med. Center Glen Burnie かりん If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 28, 9. Birthplace (State or Foreign 5. Social Security Number Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 🕅 M 2 □ F T931 Pennsylvania 181-24-8441 May **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 X No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral "natural", or items 23a United States 21061 202 Somerset Dr., Apt. 103 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give 147-169 Specify: White 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Military U.S. Army - Ret. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Chamberlain Chamber Orville Ray Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,21061$ 19a. Informant's Name/Relationship (Type, Print) 202 Somerset Bay Dr., Apt. 103, Glen Burnie, MD Sharon A. Shaffer / Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 14 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Glen Burnie, Maryland 2011 4 Donation 5 Other (Specify) Glen Haven Mem. Pk. Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 21. Sign (ture of unera Cervice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 9 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed nis certificate has been signed by the attending physician and I director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Yes 4 ☐ Pregnant g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LXNo 3 Probably 4 Dunknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Ny se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifie 29b. Signature a se of death (Item 23a) (Type, Print) 30. Name and addres W

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward aylor James 8:00 PM Jovanber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deat NIA lt.more ospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 219.38.4706 **Director** 1 XM 2 🗆 F 18 MD 10 28a-f show 10h County 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location Funeral Director must be notified MD Baltimore 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code o 10e. Street and Number 23a Rockrose Avenue Page 1 and 2 should be filed within 72 hours after death verent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 □ Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) Cab Compani Business ()wner Hnavade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ aulor KOSS Joseph Sarah 19a. Informant's Name/Relati nship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Shields Carthage Court Kandalktown MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 2011 Memorial Park Windsor Mill, MD 11116 4 Donation 5 Other (Specify) Vaugn C. Greene Flinery Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Month Medical Due to (or as a Examiner nonte Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or injury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Month Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown been sig should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? 2 No □ Yes Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 5 Pending 1 Natural 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Number Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Number Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Number Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Number Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Number Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Number Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Number Practition and the state of the cause of the c (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H00 .0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital Baltimore, 2401 WBdveder Ave ho to 11 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 30°, 1:50 PM M October Katherine Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Germantown 13131 Wonderland Way #2 If Under 1 Year If Under 24 Hrs. 5. Social Security Number unk 6. Sex Birthplace (State or Fore Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** unk Min (Month, Day, Year) Director 1 □ M 2 🔀 F Apr 15, 1952 59 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 USA 13131 Wonderland Way #2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, unk unk မ unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montgomery County Police Dept 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) in state Ronald Wage ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street ector Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ sudden cardiac death instant Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Day Month Year Yes 2 No 1 Yes 2 9 Unknown funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 9 Natural Accident 5 Pending Division 1 Yes 2 No Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ind title of certifie 29c. License number 29d. Date signed (Month, Day, Year) November 1, 2011 D28650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ran Passa MD 15245, Shady Grove Road #130 Rockville, MD 20850 nth, Day, Year) NOV 1 4 2011 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 11:30P M TAYLOR GEORGE NOVEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY COUNTY ALTHEA WOODLAND NURSING HOME SILVER SPRING If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 7 5. Social Security Number 9. Birthplace (State or Foreign 6. Se: **Funeral** Days 1**X** M 2 □ MARYLAND **Director** 230-18-5564 88 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director 1 X Yes 2 No MD PRINCE GEORGE'S 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20707 7003 FITZPATRICK DRIVE death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status was beceden Ever in 0.5. Armed Forces? 1凇 Yes 2 □ NoARMY If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT 12TH MILITARY Be 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed rtment of Health and Mental Hy rant. If item 27 is marked oth 17. Father's Name (First, Middle, Last) မ HODGE MAURICE TAYLOR MAUDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7003 FITZPATRICK DRIVE LAUREL, MARYLAND 20707 DORIS TAYLOR/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of I
Important: If it
any injury or o 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEMETERY | 11/21/11 CHELTENHAM, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Rotus 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (tylial) Interval Between Onset and Death Physician/ terio sclevota disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infirediate cause. Enter Underlying Due to for as a consection colof, Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Year the 9 Unknown P.O. ģ signed t I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 22 No cate has bage 2 s 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 4 X Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: 1X Natural 5 Pendina 1 Yes 2 🗌 No death. 2 Accident
3 Sulcide
4 Homicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L 1 🚵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License numbe

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

PAUL A. DEVORE M.D.

31. Date filed (Month, Day, Year)

D01852

4203 QUEENSBURY ROAD HYATTSVILLE, MARYLAND

NOVEMBER 10, 2011

20781

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:01 P M 2011 Regulo Rumbaua Tanguilig November Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 01ney Montgomery General Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth . Age (In yrs. last birthday, **Funeral** Days Hours (Month, Day, Year) Months 212-46-5277 Director 1 X M 2 🗆 F 79 March 30, 1932 Philippines Usual Residence of Decede shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland | Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 23a Funeral 820 Stratford Manor Terr. 20905 United States items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XX No 14. Race - American Indian, Examiner Black, White, etc o 9 1 Never Married 2 X Married oft. Page 1 and 2 should be filed within 72 hours after artment of Health and Montal Hygiene.
cortant: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: Filipino Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) architect 4 city planner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pedro Tranguilig Filomena Rumbaua 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reina Graves/daughter 1129 Kamookoa Place Honolulu, HI 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem GardNov. 14,2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Der art Import any inj once. 21. Signature of Funeral Service Licenses John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Aspiration disease or condition preumonic Medical resulting in death) Examiner Sequentially list conditions, Disability for each if any leading to in mediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the at Id be detached for 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> e hydration 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ▼No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ė Other: 2 🔀 No | 🏲 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bichhum 154996 November 2011 inh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 0:30 8 M Physician/ Novembe 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE OWSON ENTER If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number If Under 8. Date of Birth 6. Sex Age (In yrs. last birthday) Year **Funeral** 220-64-0756 Months Days Hours (Month, Day, Year) **Director** 1 M 2 F mo 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21213 USA 3333 Ave. Ramona 11. Marital Status Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N once. Elementary/Secondary (0-12) College (1-4 or 5+) Hotel COOK Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave. Balto. Thornton - brother Ramona 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Mt. Zion 11-12-11 4 ☐ Donation / D ☐ Other (Specify) 270 Fredhilton fass Balto MD 21229 yer he isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if y art failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ OF COMPLICATIONS DAYS TO WORKS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 , the attending p ched for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atter should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: autopsy perform yerrormed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 npatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title D6173 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAN-CARDEN M.D NA (Month, Day, Year) V 1 4 2011 32. Registrar's Signature State Registrar

11-08290 Shirley Ann Tyler	•	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H Certificate of Death	es Are Legik ygiene	201	1 3620
Physicia Madical Examir	n/ ner	Registrar Decedent's Name (First, Middle Last) Nirley Hnn VeR 4b. City, Town, or Location of Death	2. Date of Death Month Da November 5,	av Yeer	3. Time of Death 0840 hrs
Funeral Director		3211 Spaulding Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Mir	-	MM/DD/YYYY) 9. Birt Foreig Cou	hplace (State or number)
nd show any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits 1 Yes 2 No
Baltimore, MD 21215-0036 seruit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show nipury or other traumatite event, the Medical Examiner must be notified at once.	ral Director	10e. Street and Number 10f. Zip Code 321 Spaulding Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-		oan Indian, Black,
urs after death v ural", or item	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Yes, Sive Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done 16	Specify: Bloom Specify: Bloom Sb. Kind of Business/I	ncK ndustry
-0036 I within 72 hou giene. ther than "nat the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Home makes 18. Mother's Name	e (First, Middle, Mai	Home den Surname)	
Baltimore, MD 21215-0036 semit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", injury or other traumatite event, the Medical Examiner.	To Be C	unk. 19a. Informant's Name/Relationship (Type, Print) Lynn Williams - Caughter 2400 Poplar Dr. Gl	Rural Route Number		, Zip Code)
Baltimore, Moemit. Pages I and 2 Department of Health Important: Witem 2 Injury or other frau		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memoria Park //-	Date 2	Ramullsto	Town, State Wn mD
Physician		21. Signature of Funer- Service L ee 22. Name and Address of Facility 23a. Part Efter the disease, in complications that caused the death. Do not enter the mile of dying, such as cardiac failure.	<i>Q 70 Fred</i> or respiratory arrest	hilton Pass , shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of): b			Death
ist of 1	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		_	
760, cate be executed physician and the burial - transi		AMENDED 23a, 27, 28a-f, per me, g921 11-15 IF FEMALE: 23c. If yes, outcome of pregnancy 1 live birth 23c. If yes, outcome of pregnancy		23d. Date of deliver	y Day Year
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the buring	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregress 12 months? 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
rds, P.O. requires that the been signed by thould be detac	δ	Patt is Other significant contributing to country to the area years	24a. Was an autopsy	24b. Were a	bably 4 Unknown utopsy findings available completion of cause of
tal Reco	Be Completed	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nurse			
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be executed ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit	ation: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 4 1 1 5 Pending 28b. Time of Injury 1 1 Natural 5 Pending 28b. Time of Injury 1 1 Yes 2 X No	28d. Describe ho	winjury occurred assaulted	ural Pouto Number City
DIVIS PIPLIA OF AI FOURS after of Geral Direct filled in by	Certification:	2 Suicide 3 Suicide 4 Memicide Could not be determined or Town, Sta	te 3211 Spar	ilding Ave	

To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the

OCME 2006

Registrar DHMH 17 Rev 1/2001

Medical

State

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

29b. Signature and title of certifier

fanight withell, mi

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 6, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1059 AM David Tomoney 2011 NOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore CIty Sinai Baltimore 01 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07/23/1943 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F s.Carolina 68 215-42-6039 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Marylan 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Tomoray 1 TYes 2 No Director Baltimore N/A MD 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 3909 Clarks Lane Apt B Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Xes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black Specify ģ 3 Widowed 4 Divorced "natural", Completed or than "natur 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meals on Wheels permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumatic event, Italy once. Driver 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Tomoney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3909 Clarks Lane Apt B, Baltimore, MD21215 David M. Tomoney(son) Pt. Know 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State on-site Crematory 11/09/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) For Bridge Jr. Funeral Home PA 21. Signature of Funeral Service Licensee 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hr. estive + al **Physician** disease or condition resulting in death) /Medical Due to (or sea consequence of): Examiner pertensio Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lar Hospital or Attending Physician: The law requires that the death certificate be executed Renal Insul/1012no been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 ☐ No this certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1₽Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Nov. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D Sinai Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State backs 4 2011 NOV 1 Registrar

DHMH 17 Rev 1/2001

David

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36203 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gordon Charles Tegeler, Sr. 2011 3:20 A November 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford 2400 Hunt Place Fallston 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours (Month Day Year)
April 17, 1925 Baltimore, Maryland **Director** 212-20-5006 1 🔀 M 2 🗆 F 86 28a-f shov 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Examiner must be notified at Director Maryland Harford Fallston 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a United States Funeral 21047 2400 Hunt Place tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Carling National Bo Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Theresa Schaefer Harry Charles Teopeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Gloria E. Tegeler (Spouse) 2400 Hunt Place Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o ō November 15, 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Name and Address of Facility Evans Fineral Chapel & Cremation Services Parkville 8800 Harlord Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Listonly one cause on such line. tenial Bet Inset and Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed ician and burial-trans that initiated events resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant n the past 12 months? Dav Month Yes 2 ☐ No a Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas autopsy performed' 1 Yes 2 No Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 XResidence 6 \square Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Funeral Director; After this etely filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

4. SUN,

31. Date filed (Month, Day, Year,

MD

1 4 201

NOV

32 Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ Medical 4c. County of Death **Examiner** 8. Date of Birth
(Month, Day, Yea 9. Birthplace (State or Foreign Country) Rhode Island If Under 1 Year 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 1 **x** M 2 □ F February **Director** 036-26-8398 68 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland 1 Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or by Funeral 21230 U.S.A. 1618 South Charles Street permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc 1 K Never Married 2 Married K Yes 2 □ No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robert Taylor Nuzlie Hattab Catalani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Cerullo 1618 South Charles Street Baltimore, Maryland 21230 friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory November 10, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Polyniak Funeral Home P.A. any 130 Fast Fort Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 L Yes 2 L 9 L Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🗆 No မြ 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 11 2011 Patricia Ann Uhlman 1:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marley Neck Health & Rehabilitation Glen Burnie Anne Arundel Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) Director 176-24-4973 1 □ M 2 🗶 F 80 01/05/1931 PΑ Usual Residence of Deceden aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No MD Anne Arundel Co. Curtis Bay 10e. Street and Number rms 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 21226 1396 River Mist Court United States permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, of Health and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) l Hygiene. I other tha 12 yrs. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Moore Margaret Comer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Mr. Fred Uhlman, Sr. /Husband 1396 River Mist Court Curtis Bay, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 ី Cremation 3 🗌 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 11/15/2011 Glen Burnie, MD Atlantic Crematory Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave. SW; Glen Burnie, MD 2106 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Chronic Physician/ disease or condition Medical resulting in death) Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): and the burial-trar Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mont Month Day Vear Pregnant at time of death
Unknown signed by the at Id be detached fo 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? of a stranding Physician: The after death.

Director: After this certificate h 1 🗌 Yes Yes 2 1 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death heck only one) Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) f Death 27. Manne 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Vilatural 5 \square Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Lamus

O Du

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Back River NRCK Road

Maylad Zick

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

201-109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per dr., g921, 11-14/2011dhb, 29c dper dr/me

Certificate of Death

Reg. No. 36206 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 12,2011 6:38 A. M Joseph E. Wicker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Hospice Howard Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Hours Min Feb. 10, 1913 Country) New York 1 X M 2 □ F 072-05-0243 98 **Director** Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Oranger Newburgh New York 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code 12550 10g. Citizen of What Country? Funeral 6 Woodlawn Terrace U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 er than "natural", or t, the Medical Exam 1 Yes 2X No Specify: Specify: White 3 ¥ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene.
7 Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Company Pipefitter 8 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Sadie Dinan Ernest Wicker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Wicker 1241 Florence Road, Mt. Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-15-11 New Windsor, New York Calvary Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Qnset and Death** Ph. sician/ PARS angesti ve disease or condition Medical resulting in death) Due to (or as consequence of) Examiner ears nan 5 aguer tially list conditions, if any, leading to immediate cause. Enter Underlying CENTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Vunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performed certificate 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medica Division of Vital director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) Hospice ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA this After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 X Accident injury Fall While transferring from chair 5 Pending work? 1 ☐ Yes 2√ No 10/8/2011 unknown. Investigation within 24 hours after death

To the Funeral Director; A

completed filled in by the f 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1241 Florance Rd, MTAIRY, MD 21771 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined At home in garage 1241 Florence Rd, MIA.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60634 10/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

CEDAR LANE, COLUMBIA, MD 21044

6336

32. Registrar's Signature

JOSEPH

31. Date filed (Month, Day, Year)

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			Ame For Ame State Registrar	Pleasend Items	e Type or Pris 20b, c per State of M 28e per di	int in l r fh, arylan r , g9	Black Ir g921 , 1 6 / Deb 21,11 / Ce/	ndelib 1/18 artmer 14/21 tificat	le In /201 It of h 011d e of L	k. Ens I dhb lealth beath	ure A and M	II Copie ental Hy	s Are giene	Legible 201	e.	6207
	Physicia	an/	1. Decedent's Name	e (First, Middle, La	ast)							2. Date of De Month			3. Tir	me of Death
S	Medic Examir	cal	Anthony Glen value									10	County of De	1 3	:45 PM	
900	LAGITIM			Samarit	alt	inol	re,	MD	40.	Oddiny or Be	N/A					
	Funeral Director		5. Social Security No. 217-84-8. Usual Residence of	723	Sex 7. Ag	1e (In yrs. Ia 52	ast birthday) Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Jul	th 1, Year) 1, 1959	9. E	Birthplace (St Co <i>untry)</i>	MD
	faryland Ba-f show tified at	Director	10a. State	10b. County	nore City	10c. City	y, Town or Lo	cation		Baltir	more					de City Limits Yes 2 \(\square\) No
	with the N 23a or 29 ust be no	Funeral Dir	10e. Street and Nun		ıe			10f. Zip	Code	212	06		10g. Citi	zen of What	Country?	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Unportant: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Marri 3 Widowed	ied 2 K Married 4 □ Divorced	12. Was Decedents Armed Forces? 1 💆 Yes, 2 🗌 If Yes, Give Year or Dates.		//19/			ispanic Ori in, Mexicar Specify:		cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wh Specify:		in,
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MITE land 2	be filed wit ental Hygie ked other ic event, th	To Be C	17. Father's Name (f		Anthony Jac	kson						(First, Middle,	_			
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わっつり Baltimore.	Page 1 and ment of Heal ant: If item ury or other				☐ Removal from State	20b. P Gar	lace of Dispo	sition (Nar Fores Veterar	ne of B'ter pSo S Gerr	eate etery	Veter Nov 0	^{ate} ns C∈ 14, 2011	20c. Lo m . O	cation - City	or Town Sta Mills SVIIIE, N	temp
+	permit. Departin Importa any inju		21. Signature of Fur	neral Septide Licer	1 Estex	2						Service, F nore, Md 2				
42			shock, or hear	t fall ure. List only	nplications that second	d the death	n. Do not ente	er the mod	e of dyin	g, such as	cardiac or	respiratory a	rest,			ximate al Between and Death
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		iner	Sequentially list cor if any, leading to im	nditions, mediate	b. Due to (or as	a consequ	rence of):								16	<u>rars</u>
	executed ian and urial-transit	ıl Examiner	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	njury	cDue to (or as	a consequ	ence of):									
209	cate be	edica		•	d											
راد الاوروناد, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 5 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic Other (sp		÷y				23d. Date of o	delivery Day	Year
ls, P.O	ires that the signed by	by	Part II. Other signifi	cant conditions	contributing to death b	ut not resi	ulting in the u	nderlying	cause giv	en in Part	1.			se contribute		e of death?
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o uo	ath. r: After he fune	icate	1 Natural 2 Accident	5 Pending Investigation	(Month, Day	v, Year)	injury	M	8c. Injun work 1 🔲	Yes 2 🗌		8d. Describe l	now injury	occurrea		
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	To the Hospita within 24 hours to the Funeral completely filled	Medical	29a. Certifier 1 (Check 2	Medical Exan	ysician: To the best of niner: On the basis of e	xamination	and/or invest	igation, in	my opinio	n, death oc	ccurred at t	he time, date a	and place,	and due to th	ne cause(s) an	nd manner stated.
_	To the within comp		29b. Signature and t		4 / .	1.D.	y mountage,		. License	number		e, a 10 ces 10	29d. Dat	e signed (<i>Mo.</i>	nth, Day, Yea	r)
					<u></u>	eath (Item	23a) (Type, P	rint)	, E	Balt	rim	ore,				
	Stat Registra		31. Date filed	7 4 201	32. Registra	ar's Signati	barr					one,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

anthony Ray Wash	nington S 1- For State Registrar	tate of Maryland	•	ent of Health a te of Death	ind Mental		eg. No. 20	11 3620	
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*	3327 Walters Lane			Forestville			Prince Geor	<u> </u>	
Funeral Director	5. Social Security Number リルドルのいい	6. Sex 7. / 1 X M 2 F	Age (In yrs. last birth			Hrs. 8. Date of Bir Min. 11/10/	th(MM/DD/YYYY) 9. /1983	Birthplace (State or eign Country) DC	
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits	
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r death with or items 23 must be no	1 X Never Married 2 N	larried Armed Force		If Yes, specify Cut			White, etc		
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2 hours "natu	15. Decedent's Education (Spe Elementary/Secondary (0-12)		- dı	ecedent's Usual Occu aring most of working l			16b. Kind of Busines	ss/Industry	
5-0036 led within 72 hours after thygiene. other than "natural", the Medical Examine Completed by	10th			mployed			None		
21215-0036 Joint within 72 hours after death with the Maryland Mental Hygiene. Marked other than "natural", or items 23a or 28a-f she cevent, the Medical Examiner must be notified at once for Be Completed by Funeral Director						eme (First, Middle, I elia Wash			
imore, MD 2121; Pages 1 and 2 should be fill ment of Health and Mental H nant: If item 27 is marked or other traumatic event, I			19b.	Mailing Address (St			_	ate, Zip Code)	
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Baltimore, MI permit. Pages I and 2s Department of Health a Important: If item 27 injury or other traum.	20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal from S	State cremator	Disposition (Name of y or other place)		Date	20c. Location - City		
Baltimore, permit. Pages 1 an Department of He Important: If ite Important or other training or other	4 Donation 5 Other S 21. Signature of Funeral Service		Metropo	olitan Cre			l Alexandr me of Mary		
Depr. Depr. injin	Victarine	C. Woo	de	4308 Suit				746	
Physician /Medical	23a. Part I. Enter the disease, of failure. List only one cause		ed the death. Do not	enter the mode of dyir	ng, such as cardia	ac or respiratory arm	est, shock, or heart	Approximate Interval Between Onset and	
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Woul						Death	
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ed nsit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a con	sequence of):						
Exam Exam									
0, be executed rician and burial - transit edical Ex	UNPENDED	AMENDED							
	IF FEMALE: 23b. Was decedent pregnant in the		ome of pregnancy				23d. Date of deliv		
Box 68760 death certificate the attending physic for use as the bunysician/Me	past 12 months?	4 Pregnant	2 at time of death 5	Fetal death Other (Specify)	Ectopic pre	gnancy	Month	Day Year	
F legt be	1 Yes 2 No 9 Un Part II. Other significant condit	tons contributing to des	ath but not resulting i	n the underlying caus	given in Bort I	23e Did to	hacco use contribute	to the cause of death?	
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Division of spital or Attendin, owners after death. Meral Director: Al filled in by the fun Certification	3 Suicide 6 Coul	d not be 28e. Place of		n, street, factory, office	building, etc.	or Town, S	tate)	Rural Route Number, City	
Hospita 4 hours funeral ely fille	29a. Certifier 1 Certifier P	hysician: To the best of r		occurred at the time	date and place a		Lane, Forestville, M		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	10	miner:On the basis of ex	amination and/or inv						
T S I S	29b. Signature and title of certifie				nse number		29d. Date signed (A		
1 11	30. Name and address of person	who completed across of	death (Itam 22a)		C.M.E.		November 2, 2	VII	
,),		sistant Medical Exa		. Baltimore Stree	t, Baltimore,	MD 21223			
State Registrar	31. Date filed (Month, Day Year)	4 2011 32. Region	er's Signature						
DHMH 17 Rev 1/2001	1101-1	TOTAL STREET	ORIC	INAL	·	_		·····	

DHMH 17 Rev 1/2001 OCME 2006

OCME

Director

To Be Completed by Funeral

Examine

To Be Completed by Physician/Medical

Physician/

For State Registrar						tificat				Mental Hy	Reg.	21		3620
Decedent's Name	(First, Middle	, Last)								2. Date of De	eath		<u> </u>	3. Time of Death
GLADYS	EL	IZABETH	WI	LLIA	AMSON					November 5 2011			0 Year	13:13 p M
a. Facility Name (if	not institution	give street and no	ımber)		_	4b. City,	Town, or	Location	of Death			4c. County	of Death	1 - 1
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. Social Security No		In yrs. las	s. last birthday) If Under 1 Year If Under 24 Hrs.					8. Date of Bir	rth	erl		place (State or Foreign		
577-40-95		Yrs.	Months Days Hours Min. Oct. 2, 1932					Cour	NC NC					
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Marital Status Never Marri	od o 1521 M	12. Was Dec	orces?							ecify Yes or No- Rican, etc.)			ce - Ameri ck, White,	ean Indian, etc.
3 Widowed		If Yes, G		0	-	□ Yes	2 🔀 No	Specify	y:			Specify	c pol	a o k
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Elementary/Second 12t		College	(1-4 or 5+)			nist	,	re As	ssist	ant	PG	Cou	nty	
7. Father's Name (F	irst, Middle, L	ast)								e (First, Middle,	-			
Early Jo	nes							E11a	a Jon	es				
9a. Informant's Na		ip (Type, Print)			19b. Mailir	na Address	(Street a	nd Numb	ner or Run	al Route Numbe	er. Citv	or Town.	State, Zip	Code)
loward A.	Willi	amson -	Husba	and	7310									D. 20743
Da. Method of Disp			14000	20b. Pla	ace of Dispo	sition (Nan	ne of			Date	_			own, State
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1. Signature of Pur				LINC						0-2011				
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23a. Part 1. Enter th	e disease or	complications that	caused th	ne death								TID Z	0740	Approximate
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southly in death) t	ası	Due to) (OI as a C	onseque	siice oi).									
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art II. Other signifi	cant condition	ns contributing to	death but	not resul	lting in the !!	nderlying	ause div	en in Par	t I	220 0:-1	toboo-	0.1180.000	tributo to 1	he cause of death?
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5. Was case referre	d to medical						26. Pla	ice of De	ath (Chec	k only one)	- 4	-,10	100	
examiner?	GNo	Hospital:	Inpatient	2 30	R/Outpatier	ıt 3 □ D0	1	p.		ome 5 🗆 Resi	idence	6 □ Oth	er (Specif	v)
7. Manner of Death		28a. Dat	e of injury	2	28b. Time of	- 1	8c. Injury	at		28d. Describe				
1 Natural	5 Pendin	/A A.a.	nth, Day, Y	(oar)	injury		work'					, ,		

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

100	5	building, etc. (Specify)		City or Town, State)
Modio	29a. Certifier 1 Certifying Physicial (Check 2 Medical Examiner		n, in my opinion, death occurred a	nd due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s) and manner stated. ce, and due to the cause(s) and manner as stated.
	29b. Signature and title of certifier	in the	29c. License number	29d. Date signed (Month, Day, Year) Nowmser 7, 201
	30. Name and address of person who com	pleted cause of death (Item 23a) (Type, Print)	An orne colo	277KC4.ND 20785
ate	31. Date filed (Month, Day, Year) •	32. Pagistrar's Signature		

St Registrar

13

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink First All Copies Are Legible.

AMEND ITEM#10e, 19b, perfft, 692 First All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 15 2011 WILLIAMS 3:25 A M RUTH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S LANHAM 7930 SISKE AVENUE If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Min NOV. II NEBRASKA Yrs 1929 Director 81 508-32-2562 Usual Residence of Deceder iral", or items 23a or 28a-f show Examiner must be notified at 10d, Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 □ No MD PRINCE GEORGE'S LANHAM 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Fiske SISKE AVENUE Funeral 7930 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Decedent Ever Armed Forces?

1 Yes 2X No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after BLACK 1 Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MARY KAY MELVIN CURREN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7930 SISKE AVENUE LANHAM, MARYLAND 20706 ALTUS WILLIAMS/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a Method of Disposition Date Department of Important: If it any injury or o 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ARLINGTON NAT'L CEME 12/9/2011 ARLINGTON, VIRGINIA 22. Name and Address of Facility J. B. JENKINS FUNERAL ROME, INC. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Interval Between Onset and Death Immediate Cause (Final STAGE IV LUNG CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examin and resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical the death certificate be P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Year Month Day Pregnant at time of death Unknown 9 Unknown signed by Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed?

1 Yes 2 X No 1 ☐ Yes 2 🛛 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) in 24 hours after deam.

In 24 hours after deam.

The Funeral Director: After the funeral in by the funeral in 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the F 3 Certifyting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, OCTOBER 18, 2011 D31069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1100 MERCANTILE LANE #135A LARGO, MARYLAND 20774 GEORGE BONE M.D. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ DOROTHY WATTS 5:30 A M NOVEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S RIVERDALE CRESCENT CITIES NURSING HOME Date of bill. (Month, Day, Year 20 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex **Funeral** Days Hours Min 1 🗆 M 2 💢 F 85 SOUTH Director 1926 SEPT. CAROLINA 579-34-3867 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No PRINCE GEORGE'S UPPER MARLBORO MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö the Medical Examiner must be 23a by Funeral 35 CABLE HOLLOWAY 20774 USA items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ō Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK If Yes, Give Specify. "natural", 3 Midowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE OFFICE CLERK traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARRIE BATIE pe SAM BATIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,\,20774$ 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other traconce. 10903 W KETTERING DRIVE UPPER MARLBORO, MARYLAND MARIE STEELE/DGT. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) NATIONAL CEMETERY 11/11/2011 LAUREL, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician KIDNEY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ng physician and as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? φ Month Day Year Pregnant at time of death 2 XNo been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? Yes 2 🛭 No 1 ☐ Yes 2XX No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 2 XNo ြု 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner as tated. To the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 00064208 NOVEMBER 9 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20737 4409 EAST WEST HIGHWAY RIVERDALE, MARYLAND SAADIA HUSAIN M.D 32. Registra's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36212 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 11, 2011 3:45 А м Wilma Weeks Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Months Hours Month, Day, North Carolina Director 236-22-8139 88 .1922 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 🕅 No Long Green 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4607 Long Green Road 21092 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Completed by Black, White, etc. 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify. 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Ledford Blackburn Joseph Minnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NOVEMBER 4328 Long Green Road Cheryl Winter Daughter Glen Arm, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it Du Panetay crematory of the place)
Memorial Gardens 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Servitor) The companion of the com 11-14-2011 Timonium Maryland Ruck Towson Funeral Home, Inc. The of Funeral Service Licenses 22. Name and Address of Facility 1050 York Road 21204 Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ onges disease or condition Months Medical resulting in death) Due to (or as a pansequence of): Examiner ronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-tran that the death certificate be execut that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☑ No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work' 1 Tes Investigation 2 🗆 No Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT 2300 21093 DULANEY VALLEY ROAD TIMONIUM MD32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 4 2011 Registrar

36213

		-	State Registrar	, in the second	Certificate of L	Death	Reg	g, No.	
г	Physicia	ın/	Decedent's Name (First, Middle, Last) ETNA ANNE WEINHOL)			2. Date of Death Month November	^{Day} 0, 2011	3. Time of Death
State.	Medic	al	4a. Facility Name (if not institution, give street an		4b City Town o	r Location of Death	November	4c. County of Death	1:13P ^M
	Examin	ier	Gilchrist	a numbery	Towson	Location of Death	Baltimore		
- 40	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birth ear) Cour	place (State or Foreign
10	Director		219-40-9050 1 □ M X	X F 67	rs.	110010	01/13/19		ryland
	nd show at	ا _ة ا	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		· · ·		10d. Inside City Limits
	/laryla 8a-f s tified	Director	Maryland Baltimore	Towson					1 🗌 Yes 2 💢 📉 No
	with the N 23a or 2 Ist be no	eral Di	10e. Street and Number 929 Southwick Drive	!	10f. Zip Code 21286		10	g. Citizen of What Cou USA	ntry?
	leath v	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto		14. Race - Ameri	
980	rs after d Iral", or i Examin	ρ β	1 Never Married 2 XX Married 1 X 1 X 1 X 1 X 1 X 1 X 1 X 1 X 1 X 1	ed Forces? Wes 2 D No Vietnam s, Give or Dates.	1 ☐ Yes 2 XX No		noan, o.c.,	Black, White,	White
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lan	l be fil lental rked tic ev	ပ	Clifton Howard Anders	on		Anna Coc	hran		
Mary	ge 1 and 2 should be filed within 72 hours after death with the Manyland to f Health and Mental Hygiene. It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print, Tobert Winway Weinhold, Sr.		Mailing Address (Street Southwick Dri				Code)
Baltimore, Maryland 21215-0036	Page 1 and ment of Hea ant; If item ary or othe		20a. Method of Disposition 1 Burial 2XX Cremation 3 Remova 4 Donation 5 Other (Specify)	I from State cemeter	Disposition (Name of y, crematory or other plan nt Crematory	^{ce)} 11/15/	- 1	oc. Location - City or Taltimore, Mar	
Balti	permit. Page Department of Important; If any injury or once,		21 Agnature of Euneral Jervice Licensee	www.				feld Funeral ryland 21212	Home Inc
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75.E	Physician/ Medical		Immediate Cause (Final disease or condition	Chince cd		An tu	be		Onset and Death 4 4 4 CC
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	e exercian a		resulting in death) Last D	ue to (or as a consequence o	ī):				
8760	tificate be executed ng physician and s as the burial-transit	Medical	d						
Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed find the Athern and the Athern and the Athern and the Athern and the Euroria Director. After this certificate has been signed by the attending physician and the Funeral Director. After this certificate has been signed by the attending physician and appearance in the funeral director, page 2 should be detached for use as the burial-transition.	Physician/M	in the past 12 months?	es, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnan 5 Other (specify)	су		23d. Date of deli	very Day Year
P.O. I	t the	Phy	9 ☐ Unknown Part II. Other significant conditions contribution		the underlying cause a	ven in Part I	23a Did toba	cco use contribute to	the cause of death?
ds, P.	quires the	Completed by	Small Garrel OGSMU				1 \(\text{Yes}	54	obably 4 Unknown
con	has be	nple					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
Re	: The la cate ha ; page	Col					perform 1 Yes 2	ed? death?	2 🗌 No
ital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		_ lott	lace of Death (Check		W	100000
of V	Phys r this eral di	2	/0	1 Inpatient 2 ER/Out Date of injury 28b. T	ime of 28c, Iniu:	4 □ Nursing Ho	me 5 L Residen 28d. Describe how	ce 6 NOther (Specification)	WNOSPIGE
ou c	nding ath. :: Afte e fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) in	ijury wor	kí?] Yes 2 □ No			
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
_	e Hospit. 124 hours 5 Funera letely fille	Medical	29a. Certifier (Check conty one) 29a. Certifying Physician: Tc 2 Medical Examiner: On to 2 Medical Examiner: On to	he basis of examination and/or	investigation, in my opin	on, death occurred at	the time, date and	place, and due to the ca	ause(s) and manner stated.
	To the within To the compl	2	29b. Signature and title of certifier	It als soot of my know	29c. Licens		29	d. Date signed (Month,	Day, Year)
	1		> plante	\sim	1) 58303	1	lovember 11	2011
			30. Name and address of person who complete	d cause of death (Item 23a) (T	ype, Print)	4 0			
			31. Date filed (Month, Day, Year)		No Char	LUS ST	TONSUN	MA	
	Sta Registr		NOV 1 4 2011	32. Registrar's Signature					

State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month V Darcelle West Year LUI :32PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore NA Sinai Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Min 08-15 1 M 2 X Hours 216-72-3778 53 Director Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 3509 21207 USA Berwyn Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian,
Black, White, etc. African 11. Marital Status Armed Forces?

1 Yes 2 X No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: American 3 Widowed 4 XDivorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other tranmatic event, the Medical any injury or other tranmatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Administrative Asst. State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nicholas West Evelyn Nixon Η. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 Berwyn Avenue Baltimore,MD. 21207 Ashley Vereen-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date woodlawn Cem. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-15-11 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Formal Service License Wylie Funeral Home P.A. Street Baltimore, MD 21217 22. Name and Address of Facility 638 Ν. Gilmor 23d. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Exacerbaction disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or a inding physician and use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1, Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28b. Time of 28c. Injury at work? injury Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 3011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 altimore 0 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pearl Elizabeth Wallace 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timore Bal Franklin Square HOSPIta Rosedale 8. Date of Birth Sept. 28, 1928 9. Birthplace (State or Foreign 5. Social Security Number Year If Under 24 Hrs. **Funeral** Months Maryland 214-24-3812 **Director** 1 □ M 2X F 83 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō must be 21234 Funeral 8310 Nunley Drive Apt. C USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, "natural", or iter edical Examiner Armed Forces?

1 Yes 2 XNo δ 1 Never Married 2 Married 21215-0036 white 1 Yes 2 X No Specify If Yes, Give Year or Dates Specify: Completed 3 ☑ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Virginia Candy Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Candy Maker 12 Company Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katie Beiderbock ပ Page 1 and 2 should be nent of Health and Ment Thomas Moran traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau once. 3 Winkel Court Apt.3B-Rosedale, Maryland 21237 Randy Wallace-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Garrison Forest VA 1🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Owings Mill, Maryland Nov.16,2011 **Jepartment** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) tracran Medical Due to (or as a consequence of) Examiner oaquio Sequentially list conditions, if any leading global scause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed ACCUTION APPROVED BY MEDICAL EXAMINE oumad and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After injury Natural Accident 5 Pending 1 Yes 2 No -3-2011 Fellat Investigation unknown 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) & 310 nunley of APIC Home within 24 hours a 21234 Hospital Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 25,0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) frank Sayare Drive 1 4 2011 State Registrar

Solla

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:12am 2011 William F. White November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Grace 661 Bourbon Street If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06/22/1930 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Hours 81 Maryland Director 215-28-2104 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, its Modical Evanding must be notified at 1 Yes 2 No Director Aberdeen Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 122 Harford Street 21001 USA Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white þ 3 XXVidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumair. Manager Petroleum 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Ida D. Tayson ပ Roland White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 661 Bourbon Street, Havre de Grace, MD 21078 Mary White (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Church of the Ascension 11/10/11 Street, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature I u eral service Livensee banes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ctol corrunauna disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carry y Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 I Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 1 Tyes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director; A
bletely filled in by the fu after death. 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within 2.

Registrar

29b. Signature and title of certifier

Do cuce ne and advicess of a rson who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

Rome Headler MD (1001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:45 Novemby 201 ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner A/K Baltimore The Johns Hopkins HOSPHU If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Min Hours 221-28-3067 **Director** 1 X M 2 🗆 F 67 Apr 17, 1944 Delaware Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No New Castle Delaware Newark 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō should be filed within 72 hours after death with tand Mental Hygiene.

is marked other than "natural", or items 23a Funeral 29 East Stephen Drive 19713 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 X Married Yes 2 No þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pipefitter Plumber 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname)
Agnes (Unknown) 17. Father's Name (First, Middle, Last) Agnes ည Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 East Stephen Drive, Newark, Delaware 19713 19a. Informant's Name/Relationship (Type, Print) (Wife) Patricia Wojciechowski 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
All Saints Cemetery 1 E Burial 2 Cremation 3 Removal from State Wilmington, Delaware Unknown 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death ed by the a Unknown signed by a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I; page 2 s autopsy death? certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes ဂ္ ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 1/2 Inpatient 2 this 28a. Date of injury (Month, Day, Year) vithin 24 hours atter usa....

To the Funeral Director: After the completely filled in by the funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

North

29c. License numbe

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, Ballimore Maryland

29d. Date signed (Month, Day, Year)

Noumber 10,20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 20 ÎÎ 10:55 AMM Barbara E. Younger Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Cockeysville Broadmead Health Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Sept 11 1 □ M 2 🕅 F 1912Texas Director 553-30-9265 99 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Tes 2 No MD Baltimore Cockeysville 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21030 13801 York Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 white permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any jury or other traumatic event, the Medical Frenonce. 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home housewife 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Bowie Claude Ray Badgett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Gode) 3011 Sharon Road Jarrettsville, MD 21084 Ellen Stromdahl/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 - Qther (Specify) Sign State Addresmy Board 655 W. Baltimore Street Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, en heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Certificate: To Be Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION 24a Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital examiner? 1 \square Yes Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DCA 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural work? 5 Pending Division 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 / Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) Type, Print

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State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James Zito 6:35 b November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Emeritus-Towson <u>Baltimore</u> <u>Towson</u> 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 6, 1928 Birthplace (State or Foreign Country) **Funeral** Months Hours Director 215-22-2085 83 1 □**χ**M 2 □ F Maryland Usual Residence of Deced 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗌 Yes 2 🙀 No Baltimore Baltimore 10e. Street and Number Ь 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6451 North Charles Street 21212 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ö 2 1 Never Married 2 Married 1 X Yes 2 No
If Yes, Give
Year or Dates. 50 - 52 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify. Specify: White "natural" Completed 3 X Widowed 4 Divorced Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Je filed with that the first than "r (Specify only highest grade completed) Baltimore City College (1-4 or 5+) Elementary/Secondary (0-12) Civil Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Guiseppe Zito Guiseppina Scilacci and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Josephine Schmidt-daughter 24 Tenbury Rd., Lutherville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ь X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or Parkwood Cemetery Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 11/11/11 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William Dau 1050 York Road, Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ejehrovaxular ditale 7018 Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated see 1) Examine Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? AZSISTE d IIVIN Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence \(\text{Specify} \) Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A completely filled in by the fi Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58303 ompleted cause of death (Item 23a) (Type, Print) 6701 N. Charles ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36220 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death PAUL Physician/ ALD AMS : 15 A.M OTTOBER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Peath 4b. City, Town, or Location of Death Examiner HEALTH CARE VA MARYLAND Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days (Month, Day, Year) April 22. Country) Pennsylvania Months Hours **Director** 171-32-8233 94 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Port Deposit 1 Yes 2 X No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ortnent of realth and Menial Hyglene.

ortant: If item 27 is marked other than "natural", or items 23a o
injury or other traumatic event, the Medical Examiner must be Funeral 21904 U.S.A. 9 Foxtail Road Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, was becedent Ever III o.S. Armed Forces? 1 🔯 Yes 2 🗌 No If Yes, Give 1959-81 Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
U.S. Army (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Aberdeen Proving Ground Twelve Years Master Sergeant Aberdeen. Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl F. Adams Helen Sefick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ursula M. Adams (wife) 9 Foxtail Road, Port Deposit, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Karial 2 Cremation 3 Removal from State cemetery, crematory or other place) West Nottingham permit. Page Department of Important: If any injury or once, 10/26/11 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemeterv 21. Sigrature of Funeral Service Licer 22. Name and Address of Facility ee A. Patterson & Son Funeral Home Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate PROSTATE Immediate Cause (Final CANCER DIN KINDW'N Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami executed the burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the attending p be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: ပ 1 Yes 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl To the Funeral Director:, completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title_of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe rson who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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State

32. Registrar's Signature

MARYLAND

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31. Date filed (Month, Day,

HEALTH CARE SYSTEM

amend 11 per inf , 9921 11 28 11 sm. Please Type or Print in Black Indelible link. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 22 Frank Earl Brown 10:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9007 Taylor Street Prince George's Springdale Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 060-32-0987 Usual Residence of Deceden **Director** 1 X M 2 □ F Dec. 6, 1939 New York 71 ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Prince George's Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9007 Taylor Street 20774 USA 2 should be filed within 72 hours are:
th and Mental Hygiene.
27 is marked other than "natural", or items 12. Was Decedent Ever in U.S.

Agned Forces?

1Â⊒ Yes 2 □ No
If Yes, Give 1957-1964

Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 District of Columbia Building Inspector Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Junius Brown Alice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 Eric Brown/ Son 3433 Gateshead Manor Way Silver Spring, MD 20904 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 Department of Important: If it any injury or o cemetery crematory or other place)
Calverton
National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/2/2011 | Calverton, NY 21. Signature of Funeral 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions knos poilure if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last burial-1 physician s the buria Physician/Medical Records, P.O. Box 68760 as t IF FEMALE: Se 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 X No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital 1 X Yes 2 1 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at I Director: After to ad in by the funers 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) > mucenie modelm, ~ 10/25/11 104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUKEMIL ADDE II O 1 M D 12 12200 Annapolis Road, Suite 229, Glegg-Pale, MD Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 26, Physician/ 10:25 am October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Chevy Chase #905 5630 Wisconsin Avenue. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) New York (Month, Day,) 08/21 Days 1 🛛 M 2 🗆 F Hours Min Director 085-18-7472 88 Usual Residence of Decedent show 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕱 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20815 5630 Wisconsin Avenue. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced WWII White "natural" Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie Kessner Solomon Baruch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5630 Wisconsin Avenue, #905, Chevy Chase, MD 20815 Rhoda Baruch - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns 10/27/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee ملا 11800 New Hampshire Ave., Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea shock, or heart failure t only one cause on each line Immediate Cause (Final tailure Physician/ disease or condition resulting in death) onaestive Medical Due to (or as a c v sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of,: Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tle of d October 26, 2011 D42051 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person M.D., 5530 Wisconsin Avenue, #930, Chave Chase, Maryland 20815 David Scott Cohen, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

OCT 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland /		rtment of H ificate of D		nd Me		iene 2	011	36223
F	Physicia	n/	1. Decedent's Name (First, Middle, L	,	_1	00/1				2. Date of Deat	h	Year	3. Time of Death
	Medic Examin	al	Julia 4a. Facility Name (if not institution, g.		sley		4b. City, Town, or	Location of [October 25, 20			7:40A M
لتحسيب	LAGIIIII	<u> </u>	4441 Indigo Lane		Harwood			···	Anne Arundel				
*	Funeral Director		5. Social Security Number 6. 220–16–4949	. Sex 7. Age 1 □ M 2 1√2 F 85	(In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day,	Year)		place (State or Foreign ntry)
	nd now at	ľ	Usual Residence of Decedent 10a. State 10b. County	A	10c. City, To		ation]	12/7/19	125		10d. Inside City Limits
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	th the l 3a or 2 t be no	ral Di	10e. Street and Number 4441 Indigo Lane	,			10f. Zip Code 20776	5		1	0g. Citizen of USA	What Cou	intry?
	eath wi tems 2 er mus	Funeral Director	11. Marital Status	12. Was Decedent Ev		13. W	as Decedent of His Yes, specify Cubar	spanic Origin	n? (Specif	y Yes or No-	14. Ra		can Indian,
326	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "ratural", or items 23a or 28a-f show tie event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates.	10		Yes 2 🗓 No		dento mi	San, etc./	Specif	ack, White, _{y:} Whi	
2-0	2 hours "natur edical I	Completed	15. Decedent's (Specify only highest	Education	16	(Give ki	ent's Usual Occupa nd of work done d		of working		16b. Kind of I	Business/Ir	ndustry
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Maryland 21215-0036	e filed varial Hyged ed othe	To Be	17. Father's Name (First, Middle, Las	_		_				First, Middle, N	Meade	ne)	
aryi	age 1 and 2 should be file snt of Health and Mental I- nt: If item 27 is marked of y or other traumatic ever	,	Stephen Lewi 19a. Informant's Name/Relationship		11	9b. Mailing	Address (Street a	Ju] and Number o		Route Number,		State, Zip	Code)
	and 2 sh Health a em 27 is her tra		Julia Ann Sparkm	an/Daughter		4441	Indigo L		Harwo	od, MD	20776		
more	Page 1 alent of H		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 4 ☐ Donation 5 ☐ Other (Spe		ceme	tery, crema	ition (Name of atory or other place ematory	e) 10	Da (0/26		20c. Location Edgewa		
Baltımore,	permit. Page 1 a Department of the Important: If ite any injury or of once.	1/2	21. Signate e of Funeral Service Lice	ensee	1 11020	22.	Name and Addres	s of Facility	Georg	ge P. K	alas F	unera	1 Home
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100	h sician/		shock, or heart failure. List only Immediate Cause (Final disease or condition	Lu Lu	NG		NCER						Interval Between Onset and Death
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	cate be executed physician and s the burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequenc	e of):					<u>_</u>		
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ĝ R	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4 Pregnant at 9 Unknown			Other (specify)	,			N	lonth	Day Year
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o † <	ig Phys ter this neral di	te: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatie 28a. Date of injun (Month, Day,		Outpatient Time of injury	3 L DOA 28c. Injury	4 □ Nurs		e 5 Reside d. Describe ho			fy)
Division of	uttendir death. ctor: Af y the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	tion t be			M 1 🗆	Yes 2 N	_	of Location (St	reet and Num	her or Run	al Route Number,
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	To the Hospital or Attending Physician: " The Funds after death of the Funeral Director: After this certification political physician is not be funeral director, and the funeral director.	Medical	(Check 2 Medical Exa	hysician: To the best of n aminer: On the basis of ex urse Practitioner: To the	amination and	d/or investi	gation, in my opinio	n, death occu	urred at th	ie time, date an	d place, and d	lue to the c	ause(s) and manner stated.
_	To the comp	2	29b. Signature and title of certifier				29c. License	number	_	1	9d. Date sign	ed (Month	, Day, Year)
	/		30. Name and address of person wh	o completed cause of de	ath (Item 23a	a) (Type. Pr		1691			10-	25-	2011
	50		Stophen C. HA	MILTON, MD	116	Dep	ense H	my #i	400	Ann	pous	MI	21401
	Stat Registra		31. Date filed (Month, Day, Year) OCT 26	2011 32. Registrar	rs Signature	9. 4	race						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24 Corinne Black Oct. 2011 5:55 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number 8. Date of Birth (Month, Day, Ye Nov. 16, If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 1 Days Min Months Hours 1925 Massachusetts Director 049-18-5828 85 Nov. Usual Residence of Decedent show ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Rockville 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 Veirs Drive 20850 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: White 3 Midowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Frederick Manning Florence Jansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Christina Black-Daughter 1 and 2 s of Health a item 27 i 500 E. 85th St., New York, NY 10028 3A 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Metropolitan Crem. 10/26/11 Alexandria, Va. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility 2222-Wisconsin Ave., NW HYSONG CO. Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Comminuted Fracture of Left Femur disease or condition Medical resulting in death) MO Examiner Fa11 Sequentially list conditions, Examine Due to jor as a consequence of cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed Osteoporosis that initiated events Due to (or as a consequence of): resulting in death) Last inding physician a use as the burial-t Physician/Medical Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Alzheimers Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autonsy performed? Yes 2 No death? 2 🗌 No 1 Tyes Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 | No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 K Other (Specify) Hospice After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 2 X Accident 9:00 Unwitnessed Fall 24 hours after death.

Funeral Director: A 10-12-2011 1 ☐ Yes 2X No Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28 Location (Street and Childer TWA, State) ROCKVIIIe, Miler or Furd Foute Number 3 MD 20850 completed filled in by determined Villages at Rockville Medical 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29 c. License numbe 29d. Date signed (Month, Day, Year) D37142 October 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 6001 Muncaster Mill Rd., Rockville, Md. Coleman, MD 31. Date filed (Month, Day, Year) OCT 3 1 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Barrett 26, 2011 3:30P Kathleen October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George 10005 Mike Road Fort Washington 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1271471946 Connecticut 1 🗆 M 2 💢 F 64 Director 046-40-6372 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State Director 1 Yes 2 X No Fort Washington Prince George Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20744 USA 10005 Mike Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 😿 Married "natural", or Completed by Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🎇 No Specify: 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher P.G. County traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ည Alfred Raymond Fiore Veronica Everette Blv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Raymond T. Barrett/Husband 10005 Mike Road, Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem 12/21/2011 | Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 21. Signat of Funeral Service License alas that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23d. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death CARDIOVASCULAR ATHERO SCLEROTIC Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for de a consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? the Hospital or Attending Physician: The law requires that the death 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 Yes 2 No 3 Probably 4 Unknown HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director. After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 53782

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 21, 2011 1:47 Mary Crowder Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Prince George's Bowie Health Care Center Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Days Hours 183-20-2084 Director 1 - M 2 X F March 4, 1923 Georgia 88 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Prince George's |Marvland| Bowie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 4803 Rocky Spring Lane 20715 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 XNo 72 hours after Maryland 21215-0036 1 Yes 2 XNo Specify If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates. Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Queens Casual Inc. Presser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Hitem 27 is marked of ၉ Delaware Hooks Essie Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste Castro/ Granddaughter 4803 Rocky Spring Lane Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite cemetery, crematory or other place)
Lakemont
morial Gardens 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/28/2011 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home any aire 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cardiac Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No for Month Year Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Certificate: To 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No s after death Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the 29c. License number 29d. Date signed (Month, Day, Year) D43351 10/21/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikech Fred Okwara, M.D. 12200 Annapolis Road #316 Glenn Dale, MD 20769 31. Date filed (Month, Day, Year, istrar's Signature

Registrar

State

262011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36227 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT Physician/ 4:18 PM CHRISTINE LOUISE CARLIN 2011 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY NORTH POTOMAC 12417 KEENELAND PLACE If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 7. Age (In vrs. last birthday) Days Hours Min. Country) 1 □ M 2 🔽 0 Month 2 Day/ 951 PA 192-40-1668 60 Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland Director Examiner must be notified MONTGOMERY NORTH POTOMAC 1 Yes 2 No 0 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 23a Funeral 20878 12417 KEENELAND PLACE items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. 0 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) LAW PARALEGAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN R. LITWAK ANN MCANDREW ess (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KEENELAND PL., N. POTOMAC, MD 20878 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str. 1 2 4 1 7 KE JAMES R. CARLIN, JR/SPOUSE 20a Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Data cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/28/201 STAUFFER CREMATORY MD FREDERICK, 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature # Lice P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition LUNG CANCER resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 as the l attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for Month Year Day Pregnant at time of death the a g Unknown 9 Unknown P.O. I þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Records, 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? the Hospital or Attending Physician; The Inin 24 hours after death.

The Funeral Director; After this certificate hapleted filled in by the funeral director, page 1 Yes 2 No Yes 2 Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 2 No 1 Tyes 5 Residence 6 Other (Specify ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Watural 5 Pending injury work? 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I comple only one 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D35635 OCTOBER 27, 2011

Registrar

3

State

9715 MEDICAL CENTER DR., ROCKVILLE,

MD

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

JOSEPH KAPLAN,

Day Year

31. Date filed (Month)

amend 23a.pt.I.Pt.II.25,27,28a-f,per me,g922 12-14-11 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of M	laryland /		rtment o tificate o				iene leg. No. 2 (36228	
			Registrar 1. Decedent's Name (First, Middle, Le	ast)	DEET I		mouto			2. Date of Dea	h	Year	3. Time of Death	
	Physicia Medic	al	BARBARA JEAN CAMPBELL OCTOBER 24,2011 Year								7:40A M			
	Examin	er	4a. Facility Name (if not institution, glv FREDERICK MEMOF	re street and number) IAL HOSPIT	CAL			b. City, Town, or Location of Death FREDERICK			4c. County of Death FREDERICK			
**	Funeral	-		1 DM O NE	ge (In yrs. last b		If Under 1		Jnder 24 Hrs.	8. Date of Birth	Year) 10//	9. Birth	nplace (State or Foreign ntry) ryland	
	Director		220-40-0223 Usual Residence of Decedent	I L IVI Z LA F	67	Yrs.				March 1	5, 1944	Ma	ryland	
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	Mary 28a-f	Director	Maryland Freder	ick			Freder			- т	10g, Citizen of	What Co.		
	ith the 23a or st be r		10e. Street and Number 1082 Rocky Spri	nos Road			10f. Zip Co	2170:	2		•		States	
	tems tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. W	/as Decedent	t of Hispan		ecify Yes or No- Rican, etc.)		ce - Ameri	ican Indian,	
36	after d l", or i xamin	by	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give	No		Yes 2	_		thoun, etc.,	Specif		White	
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au(be file lental l rked o ric eve	인	Frank Wilt	,						adys Ma				
lary	should and N is ma auma		19a. Informant's Name/Relationship			9b. Mailin	g Address (S	treet and N	Number or Rura	Route Number	City or Town,	State, Zip	Code)	
e, 	and 2 Health em 27 ther tr		Brenda Campbell 20a. Method of Disposition	/ Daugnte			sition (Name			Date	20c. Location			
nor	age 1 ent of nt; If it		1 □XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		e ceme	tery, crem	atory or othe	er place)	i	28/2011		•	, Maryland	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant in a property of the	21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frede												
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	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last	Due to (or as	s a consequenc	e of):		C	100	ION APPROVED BY MEDICAL EXAMINER				
760	icate b physi s the b			d					CERTIFICA					
P.O. Box 687	eath certifice attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal de	ath 3	Ectopic pre				23d. E	ate of del		
Bo	e death the att hed for	ysici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of deat 1	h 5∟	Other (spec	cify)			1	/lonth	Day Year	
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Division of Vital Records,	ician: The law certificate has rector, page 2	Cor	25. Was case referred to medical	1			_	26 Place	of Death (Chec	1 Tes	2 No		s 2 No	
Vita	ysicial s certii directo	To Be	examiner? 1 XYes 2 X No	Hospital:	atient 2 - ER/	Outpatier		Other:		ome 5 Resid	dence 6 🗆 O	ther (Spec	cify)	
of	ng Ph fter th		27. Manner of Death	28a. Date of in (Month, D	lay, Year)	o. Time of injury		lnjury at work?		28d. Describe l	ow injury occu	rred c hea	d on	
sion	I or Attending after death. Director; After i in by the funer	Certificate:	2 XAccident Investigat 3 ☐ Suicide 6 ☐ Could no	t be 28e Place of Ir		nknow			2 X No	retrige 28f. Location (ject struck head on rigerator ocation (Street and Number or Rural Route Number,			
Ω̈́	alor A s after al Direct ed in by		4 ☐ Homicide determine	building, e	etc. (Specify)	Hon				City or Tov	n, State) 10 edericl	82 Ro	cky Springs	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Chack 2 Medical Eva	hysician: To the best of miner: On the basis of	examination an	d/or invest	tigation, in my	zopinion, d	death occurred a	at the time, date a	and place, and o	due to the a	cause(s) and manner stated.	
	Fo the within 2 Fo the comple	ž	only one) 3 L Certifying N 29b. Signature and title of certifier	lurse Practioner: To th	ne best of my kn	owledge,		id at the tim icense nui		ice, and due to tr	e cause(s) and 29d. Date sign			
			· Courter	me me				11319	•		October			
	S		30. Name and address of person wh		1 (02)	P 4	Print)	ا ملا	SL.	- -	1 1	100	0, 21701	
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signature	We	XT I	IN	Jule	1 The	XXXXXX	141	v, a' / v !	
	Registr		001272	UII Care	une A.	· Alle	She Karan							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36229 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 26 07:20 AM OCTOBER 2011 ALICE MAY DOYLE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** CECIL ELKTON 59 CLEAR CREEK GLEN 8. Date of Birth (Month, Day, Yea. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 If Under 24 Hrs. Social Security Number **Funeral** Hours Director 200-38-5930 Usual Residence of Decede 1 □ M 2XXF OCT. 1,1921 90 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director must be notified 1 Yes 2XXNo MARYLAND CECIL ELKTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 23a Funeral UNITED STATES 59 CLEAR CREEK GLEN death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Black, White, etc. ō by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: WHITE 3√√Widowed 4 □ Divorced "natural", Completed Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME the HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BESSIE IRENE MILSON 0 CALVIN FORSYTHE it. Page 1 and 2 should be irtment of Health and Men irtant: If item 27 is marke other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 59 CLEAR CREEK GLEN, ELKTON, MARYLAND ALICE M. MURDOCK / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name o Date 1 Burial 2 Cremation 3 Removal from State PHILADELEHTA MEMORIAL OCTOBER 31, injury or FRAZER, PENNSYLVANIA Donation 5 Other (Specify) Departri Importa any inju once. 22. Name and Address of Facility CROUCH FUNERAL HOME. P.A. 21. Sign STREET, NORTH EAST, MARYLAND21901 SOUTH MAIN Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ DDNdisease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dué to (or as a nonsequence of): Examine Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) signed by the at g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autops Director: After this certificate Hospital or Attending Physician: 24 hours after death. To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No ☐ Accident☐ Suicide Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Name and address of person who completed Run RD Balto, MD 21221

DHMH 17 Rev 06-2011

State Registrar 2 RDDID

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36230 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT Day VIRGINIA DEMITRAL 6:50 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HEBREW HOME ROCKVILLE MONTGOMERY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You DEC 12, 1 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2X F Hours Country) Director 327 14 8354 96 .1914 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at aprile. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DE NEW CASTLE WILMINGTON 1 🔀 Yes 2 🗆 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2416 WEST 7TH STREET 19805 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify WHITE Completed 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RECEIVING CLERK RETAIL SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PETER MUNGER PATRICIA ECONOMY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE MANDES 9112 WILLOW POND LANE, POTOMAC, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State OCT 29, SILVERBROOK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) WILMINGTON, DE 21. Signature of Funeral Service Licenses DE 19805 22. Name and Address of Facility m MEALEY FUNERAL HOME, PO BOX 2866, WILMINGTON 9 23a. Part 1. Enter the disease, or conshock, or heart failure. List only producations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Dish to (or as a nonsequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy the Hospital or Attending Physician: The law requires that the death Month Year 5 Other (specify) Day Pregnant at time of death 9 Unknown g Unknown ->**Q** ->0: signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, No 3 Probably 4 Unknown Completed 1 🗌 Yes funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No မ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 30. Name and address of person who complete d cause of death (Item 23a) (Type Frint) MONTLOSE 20, D

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Mor

8 2011

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32. Régistrar's Signature

			Please Type or Print				-	•			
		-	1 - State of Mary		artment of H <i>rtificate of D</i>			ene g. No. 2011	36231		
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Evelyn Y. Downs				2. Date of Death 3. Time of Death October 23 2011 1015				
	Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Deat			
تمسد			Anne Arundel Medical Cer		Annap		8. Date of Birth	Anne A			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In Usual Residence of Decedent 6. Sex 1 \square M 2 X F	9 yrs. last birthday) 67 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	9. Birthplace (State or Foreign Country) Maryland				
	//aryland 8a-f show tified at	Director		oc. City, Town or Lo Annapol					10d. Inside City Limits 1 ☐ Yes 2 🏅 No		
	s 23a or 2	Funeral Di	10e. Street and Number 701 Glenwood St. Apt 621	L	10f. Zip Code 2140	1	10	ng. Citizen of What Co	untry?		
336	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2X No	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1 :	e, etc.		
Baltimore, Maryland 21215-0036	in 72 hours e. nan "natur Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give	dent's Usual Occupa kind of work done d OO NOT use retired)		ing 1	6b. Kind of Business/	Industry		
21	ygien yer th		10th 0	F	Bus Driv			Lane Bus	Co.		
land	d be filed fental Hy irked oth tic even	To Be	17. Father's Name (First, Middle, Last) Thomas McGhee		18. Mother's Name (Fill Rebecca						
ary	and Mandis mais ma	174	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street a	and Number or Rura	l Route Number, C	City or Town, State, Zip	Code)		
Σ,	nd 2 sealth m 27		William Downs Jr.(Son)			St. Ani		, Md. 21			
more	Page 1 a nent of H ant: If ite ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place Cremator	e)		Baltimor			
Balti	permit. Page Department of Important: If any injury or once,	21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 1922 Forest Dr. Anna						_			
wee .	Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	es tive	1.4	4 Fail		t,	Approximate Interval Between Onset and Death		
68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical Exar	1 Yes 2 No 4 Pregnant at tin	oregnancy □ Fetal death 3 □	Ectopic pregnanc	·y		23d. Date of de Month	livery Day Year		
P.O.	that the oned by the detache		Part II. Other significant conditions contributing to death but r	not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobacco use contribute to the cause of deat				
	quires en sigr	ted b	Failure to Thrile				1 Yes 2 No 3 Probably 4 Prunknown				
Recor	The law ate has page 2	Completed by					24a. Was an autopsy perform 1 \(\sum Yes \) 2	prior to death?	topsy findings available completion of cause of		
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?			ace of Death (Check	k only one)				
fΝi	Physi this c	은	1 Tespatient 27. Manne Death 28a. Date of injury	2 ER/Outpatie		4 ☐ Nursing Ho	ome 5 Resider 28d. Describe hov	nce 6 Other (Spec	:ify)		
0 U	iding I th. After funer	cate	1 Aatural 5 Pending (Month, Day, You 2 Accident Investigation		work	Yes 2 □ No	260. Describe nov	v Injury occurred			
Division of Vital Records,	or Atten	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (\$		reet, factory, office		28f. Location (Stre City or Town,	Street and Number or Rural Route Number, wn, State)			
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 Ortifying Physician: To the best of my conly one) 3 Certifying Nurse Practitioner: To the best of exam	nination and/or inves	stigation, in my opinio	on, death occurred at	t the time, date and	I place, and due to the	cause(s) and manner stated.		
	To th To th	-	29b Signature and title of certifier		29c. License	number	29	d. Date signed (Mont.	h, Day, Year)		
	•	(DO	2002 85	41	1/62/0			
0	AL		30. Name and address of person who completed cause of deat	Inne a	undel in	edical(ent	Anna pel	5 MDZ140		
	Sta Registr		31. Date filed (Month, Day, Yeal) 32. Registrar's OCT 2 7 2011	Signature d.	backer			•			

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director:
completely filled in by the f

25. Was case referred to medical			26.Place of Death (Check	only one)	
examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3 D	OA Other Nursi	ng Home 5 Residence	e 6 Other: Scene
27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	occurred
1 Natural 5 Pending	(Month, Day, Year) fd 11-2-11	fd 12:40 am	1 Yes 2 X No	unknown	
2 Accident Investigatio 3 Suicide 6 X Could not b	28e Place of Injury - At h	ome, farm, street, factory	, office building, etc.	28f, Location (Street and or Town, State) 6 N	Number or Rural Route Number (
4 Homicide determined	(Specify) Found:	Residence		Frederick, Mo	1.
	n: To the best of my knowled				
	On the basis of examination a	and/or investigation, in my	opinion, death occurred	at the time, date and place	, and due to the cause(s)
	and manner stated.				
29b. Signature and title of certifier		290	c. License number	29d. Da	te signed (Month, Day, Year)

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD

31. Date filed (Month, (Day, Year) State Registra

November 2, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October 24, 2011 Physician/ 8:30A. Scott Edward Dyson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 902 Turning Point Ct. Frederick Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Funeral O Month Pay Year) 1 🖾 M 2 🗆 F 37 Director 215-90-6678 Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Frederick MD Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21701 902 Turning Point Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 foreman carpentry permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Patricia A. Congdon Ray S. Dyson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Dyson/mother 5321 Concord Ct., Mt. Airy, MD 21771 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 10/26/2011 Frederick, MD Stauffer Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician/ 21 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 2 should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director. Be examiner? Other: 4 \(\sum \) Nursing Home \(5\)\(\sum^1\) Residence \(6\) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Matural Natural 5 Pending 1 Yes 2 No after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-25-11 D43091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tour Home Ave, frederick, MD 3170/ 13 Sace Caridi 31. Date filed (Month Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36234 State Certificate of Death Rea. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Delath 3. Time of Death Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel #101 Annapolis 603A Admiral Dr. 9. Birthplace (State or Foreign Social Security Number ge (In vrs. last birthday If Unde Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Country) 249-44-7069 Director 1 M M 4/7/1933 78 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. Count 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director 1 Yes 2XX No MD Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? Funeral 21401 ·USA 603A Admiral Dr. #101 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S 11 Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Maryland 21215-0036 White 1 Yes 2 XXo Specify: Completed 3x Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Computer Operator Ft. Meade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ၉ Anna Phillips Robert Hambright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mechanicsburg, PA 17055 Laurel Bixler Daughter 100 Woodside Dr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/25/2011 Maryland Veterans Crownsville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Fune al Service License 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Ph sician/ Chronic 155 disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-trans Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 use as the been signed by the attending IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Year Day Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ pe 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 Yes 2 No Yes 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital ပ 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Deatl 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check within 2 To the F only one) 29b. Signa tere and title Name and address of person wh eted cause of death (Item 23a) (Ty ENSE HWY 0 trar's Signature 31. Date filed (Month, Day, Year) 32. Rec State OCT 26 201 Registrar

11-08058

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Darwin Eugene			tate of Maryland					al Hygiene		36235	
		1- For State Registrar		Cen	tificate o	f Death			g. No.		
Physici Medical Exami		Decedent's Name (First, Mid						2. Date of Deat Month October 27		3. Time of Death 1136 hrs	
Medical Exami	1161	Darwin Eugene 4a. Facility Name (if not institut				4b. City, Town, or	Location of I		7, 2011 4c. County of		
-		26 Middleton Lane	, •			Rising Sun			Cecil	7.	
Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. la	st birthday)	If Under 1 Yea			h(MM/DD/YYYY)	Birthplace (State or Foreign	
Director		161-28-8737	1XM 2 F		77 Yrs	Months Day	s Hours	Min. 01/24/	1934	Country) PA	
any		Usual Residence of Decedent 10a. State 10b. Count	,	Inc. City	Town or Local	ion		•		10d. Inside City Limits	
≥ 1		MD Cec								1 Yes 2 No	
Maryland 28a-f show d at once,	ᅙ	10e. Street and Number	TT	KIS	sing Su	10f. Zip Code		10	g. Citizen of Wha		
the Ms in or 23	Director	26 Middleton	I.ane			21911			USA		
with ms 23 be no	Funeral	11. Marital Status	12, Was Decedent			as Decedent of Hi		? (Specify Yes or No-	14. Race -	American Indian, Black,	
r death or ite	5	1 Never Married 2	1 Yes 2	X No				uerto Rican, etc.)	White,		
s after rral",	2	3 X Widowed 4 D 15. Decedent's Education (Sp	ivorced If Yes, Give Year or Dates:			Yes 2 X No			Specify: 16b, Kind of Bus	White	
2 hour	ğ	Elementary/Secondary (0-12				nt's Usual Occupa nost of working life			TOD. KIND OF BUS	iness/industry	
D36 thin 7 than fedica	Completed	12							Chemic	Chemical	
5-0 led wi		17. Father's Name (First, Middl	e, Last)	<u>'</u>				Name (First, Middle, N	e, Maiden Surname)		
121 d be fi lental	BB	John Ferster			T			e Neidig			
ID 2 shoul and N 7 is m	٩	19a. Informant's Name/Relation Wayne Ferster				•		er or Rural Route Num Rising Su			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menal Hygiene. Important: If tiem 77 is marked other than "matural?, or items 33a or 28a-f shou injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	20a. Method of Disposition			lace of Dispos	sition (Name of ce		Date		City or Town, State	
NOrdages lant of late of other		1 X Burial 2 Crematic	_	a.e	rematory or ot	herplace) :ingham (Com .	11/3/2011	Colora,	MD	
altin mit. P partme portar	ł	4 Donation 5 Other 3 21. Signature of Funeral Same		wes	22.1	Name and Address	s of Facility				
E E E	4	R.T. Foard Funeral Home, 111 S. Queen St. Rising S								1911	
Physician Medical	1	23a. Part I. Enter the disease, of failure List only one caus	or complications that caused e on each line.	the death.	Do not enter t	he mode of dying,	such as card	diac or respiratory arre	st, shock, or hear	t Approximate Interval Between Onset and	
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executed an and al - transit			d								
e ex	dical	UNPENDED AMENDED									
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tox 68760, eath certificate be attending physic for use as the bur	Cia	past 12 months?	4 Pregnant at	birth 2 Fetal death 3 Ectopic pregnancy nant at time of death 5 Other (Specify)					Month Day Year		
Box e death c the atten ed for us	Physici	1 Yes 2 No 9 U	nknown 9 Unknown								
F, P.O. ires that the signed by	by P	Part II. Other significant cond	itions contributing to deat	h but not re	sulting in the	underlying cause	given in Part			pute to the cause of death? Probably 4 Unknown	
S, F quires en sign										ere autopsy findings available	
Records, The law require freate has been si	Completed			-				autops	sy pri	ior to completion of cause of eath?	
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ion tendion eath.	흲		(Month, Day,Y	'ear)		1 🗆	Yes 2 N	0			
Division of Vital tal or Attending Physician: 18 after death. al Director: After this certiled in by the funeral directors.	ifica		estigation 28e. Place of Ir	ijury - At hoi	me, farm, stre	et, factory, office t	ouilding, etc.			r or Rural Route Number, City	
DIVI Hospital or .24 hours after Fuocral Directly filled in	Certification:	4 Homicide det	ermined (Specify)					or Town, St	ate)		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Fuoral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		100000000000000000000000000000000000000	Physician: To the best of mainer:On the basis of exa								
To the within To the comp	Medical	29b. Signature and title of certif	and manner stated.		id/or investiga	29c. Licens		ned at the time, date a		d (Month, Day, Year)	
		Chr	10-111			O.C.			October 28,		
7	}	30. Name and address of person	n who completed cause of o	leath (Item 1	23a)						
/			Assistant Medical Exa	•		altimore Stree	et, Baltimo	re, MD 21223			
St	ate	31. Date file Montil Day, Year	32. Registra	r's Signatur	e /	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2011 Physician/ Gordon Bernard Fisher 7:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Logation of Death 4c. County of Death Examiner Boonsboro Washington Reeders Memorial Home 8. Date of Birth (Month, Day, Year) July 24, 1931 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Hours New York 1**XX**M 2 □ F 80 Months 080-24-6698 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f shov Director Frederick Frederick Maryland ₩X Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 Funeral 115 Crosstimber Way USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 X Yes 2 No 1950traumatic event, the Medical Examiner Black, White, etc. 0. 1 Never Married 2XXMarried Completed by 1977 Yes 2X No Specify: white Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 1954 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Air Force Plans administrator Be 18. Mother's Name (First, Middle, Maiden Surname)
Charlotte Beal 17. Father's Name (First, Middle, Last) ပ Frank B. Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Crosstimber Way, Frederick, Maryland 21702 19a. Informant's Name/Relationship (Type, Print) Mary Louise Fisher - wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Frederick, Maryland 10-25-2011 Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland anulle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RIGHT LUNG disease or condition resulting in death) CARCINOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be attending physi I for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ate has been signed by the page 2 should be detached P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ CARDIO 1 Yes 2 No 3 Probably 4 Unknown SCLERO TIC Records, Completed 24b. Were autopsy findings available 24a. Was an FUBRICKATION PURASE ATRIAL prior to completion of cause of death? autopsy performed? 2 No DEMENTIK 1 Yes certificate 1 Yes 2 H To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 \(\text{Yes} 2 4 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCTOBER 23, 2011 - net mo D(8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

State Registrar Dr. Vasant Datta

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

340 Mill Street, Hagerstown,

301-739-7100

MD 21740

State of Maryland / Department of Health and Mental Hygiene 36237 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. 25, Day 2011 Year Dorothy Sue Lunson Farinato 3:57 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day Y 1 🗆 M 2 💢 Days Months Hours Virginia 60 1950 Director 229-76-0553 Nov. 0357 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location with the Maryland Director notified 1 Yes 2X No Maryland Montgomery Damascus 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 0 other traumatic event, the Medical Examiner must be 23a Funeral 28309 Kemptown Road 20872 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11, Marital Status Armed Forces? Black White etc. "natural", or þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) 12 Animal Protection Humane Society arinato, sue Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file alth and Mental F မ Bushfield Dorothy Cramer Robert Lunson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or Art Damascus, Maryland Richard H. Farinato - Husband 28309 Kemptown Road, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Metropolitan Crematorium 10/26/1 Alexandria, Virginia 4 Dolnation 5 Other (Specify) 21. Signature of Fun 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 20872 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ a Spontaneous cardiac disease or condition Medical resulting in death) ue to (or as a consequence of Examiner Sequentially list conditions Due to lor as a consequence of if any, leading to immed cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the ding phy as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death 1 Yes 2 q g Unknown the Unknown P.O. detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was an autopsy performed 2 page 2 s 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No ဂ္ 1 Inpatient 2 PR/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After Natural injury 5 Pending Accident death. n 24 hours after death.

le Funeral Director: A pleted filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check within 2 only one 29b. Signature and title of certific October 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Ctr Dr. Rockville, MD 20850 Sckiff MD 9901 man

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

Registrar's Signature

Corsera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25. 2011^{Ye} D. Gillis October Josephine 5:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Queen Anne Centreville Corsica Hills Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Hours 2/20/1929 1 M 2 X F Mary land 82 Director 217-24-1351 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 1920 Minnow Creek Road 21409 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Spacify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Smallwood other traumatic Summers Rebecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Welches Drive, Edgewater, MD 21037 Bonnie Huttinger/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ី Cremation 3 ☐ Removal from State injury or Kalas Crematory 10/26/2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Signature of Funeral Service Licenses 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Peath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last nding physician Physician/Medical nears use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2XI No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier mans Lane, Easton, MD 21601 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

26201

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 25, 2011 8:45 Louise D. Groves Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Manor Care-Bethesda Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 579-40-9293 **Director** 1 □ M 2 🔀 F 79 Yrs 18, 1932 Feb. D.C. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f shomust be notified at 10a. State Director 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2445 Lyttonsville Road, Apt. 316 20910 USA "natural", or items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, et by 1 Never Married 2 Married White Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Deto Mary Frances Lysaght 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2091019a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Kathleen Groves/Daughter 2445 Lyttonsville Road, Apt. 316, Silver Spring, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State Oct. 31, 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 2011 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Coronary Artery Disease Sequentially list conditions, the street of the cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial trapsit requires that the death certificate be executed Pneumonia and that initiated events resulting in death) Last Due to (or as a consequence of) as the burial Physician/Medical Box 68760 the attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 4 Pregnant a Pregnant at time of death signed by the ar Yes 2 X No 1 Yes 2 Dinknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Colon Cancer, Failure to Thrive, Urinary Tract Infection 1 Yes 2 X No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k , page 2 autopsy 1 ☐ Yes 2 🗷 No 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 Tes 2 K No ൧ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation ☐ Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Completely filled in by 4 Homicide determined City or Town, State) ဳ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Raman Tuli,

OCT

2 5 2011

31. Date filed (Month, Day, Year,

D19609

10810 Darnestown Road, #202, Gaithersburg, MD 20882

October 25, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, Physician/ 11:46 pm Jennie Wilma Geiser October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs Date of Birth **Funeral** Days Min (Month, Day, Year) Director 234-42-9791 1 □ M 2 🛣 F Yrs. 85 June 15,1926 West Virginia Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shorms the notified at 10a. State 10b. County Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20903 u.s.A. 1502 Moffet Road items ? death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify "natural", Completed 3 X Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ William J. Harold Estella M. Lantz permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 Parham Road, Silver Spring, Maryland 20903 Nancy L. Frame - Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cem. & Chapel 11/01/2011 Gwynn Oak, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO1564 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ <u> Atheroselerotic Cardiovascular Disease</u> disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or se a conesquence di). Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate Peopropietely filled in by the funeral director, page. 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ည 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) D68904 October 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Jump,

Alfred G.

M.D.

1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) October 25^{ay} 2011^{ear} Physician/ Gallie 3:52 PM [™] Walter Aloise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 146-18-0932 Director XXX 2 F June 22, 1924 Yrs. New Jersey 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2XXNo Marvland Prince George's Ft. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20744 USA 1305 Swan Harbour Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S ed Forces? Kyes 2 🗆 No 1947-Black, White, etc 1 Never Married 2XXMarried XXYes þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates. Specify: White 1968 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5.+) Elementary/Secondary (0-12) Federal Government Meteorologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Louis Gallie Katherine Jungman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1305 Swan Harbour Rd. Ft. Washington, Maryland 20744 Marjorie A. Gallie / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State Arlington Nat. Cem. 5 Other (Specify) 01/26/2012 Arlington, Virginia 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home PA heral Service Livensee 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ferior Myocardial In Physician/ disease or condition resulting in death) Medical **Examiner** oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the standard of the s Exam Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 🗌 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my informacy, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 29c. License number 16-11 10 42609 1041 who completed cause of death (Item 23a) (Type State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death OCTOBER 29 2011 4c. County of Death 4b. City, Town, or Location of Death CECIL ELKTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours

For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 12:20 AM JEANETTE MAY HAYNES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** LAURELWOOD CARE CENTER 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Min. 1 - M 2 X F JULY 26 1934 OLEAN, NEW YORK 77 **Director** 080-26-8058 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County filed within 72 hours after death with the Maryland al Hygiene. ad Hygiene. d other than "natural", or items 23a or 28a-f shov 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State Director XX Yes 2 No ELKTON MARYLAND CECIL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 21921 100 LAUREL DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 No þ 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed Medical Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the BANKING BANK PROCESSOR 12 Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatical once. 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ည DOROTHY MAY PIERCE CLAUDE RAYMOND WEAVER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 SPRUNCE COURT, ELKTON, MARYLAND 21921 19a. Informant's Name/Relationship (Type, Print) NANCY L. BERSTLER / DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 XCremation 3 Removal from State MAYERDÁLE CREMATORY NEWARK, DELAWARE 4 Donation 5 Other (Specify) 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEART FALLURE Physician/ CONGESTIVE Medical resulting in death) Examiner ARTERV CORONARY Sequentially list conditions Examine Due to (or as a consequence oi): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2,8hould be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: injury 5 Pending work 1 Yes 2 No Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00065733 10/3/11 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. HIGH SMEET, ELKNON, MD 21921 NARMANA V- PULA (26 A RA 31, Date filed (Month, Da 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hines October 2011 7:30 Joan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1470 Heather Ridge Court Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🏻 F Days Hours Aug. 22 New York Months 1952 Yrs **Director** 088-54-0534 59 Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Frederick Frederick 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1470 Heather Ridge Court 21702 United States Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 🛮 Never Married 2 🗆 Married þ Maryland 21215-0036 **Black** If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 other traumatic Zedekiah Hines Mattie Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1470 Heather Ridge Court Temikki Morrison / Daughter Frederick, Maryland 21702 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place, injury or October Department Important: If any injury or once, 4 ☐ Conation 5 ☐ Other (Specify) Frederick, Maryland Stauffer Crematory 2011 Stauffer Funeral Homes, P.A. 21. Sign ture o 22. Name and Address of Facility 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Proysiciana disease or condition seconds Medical resulting in death) Due to (or as a conseque Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ovarian Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2 No 1 Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\sqrt{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1- Natural injury 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the f 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, MD

State Registrar Registrar's Signature

46 B Thomas Johnson Dr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #5 Per FH G922 12707/2011 JH State of Maryland / Department of Health and Mental Hygiene 36244 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 8:00 a. Ruth D. Herring 2011 20 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 608 Taney Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Pay, Aug 20, 007-09-4654 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Maine 93 ^Y1918 220-54-4857 Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Frederick Frederick Maryland 1X Yes 2 □ No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21702 Funeral 608 Taney Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3XXWidowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed with...
*at Hygiene.
*ar than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important; if item 27 is marked other the any injury or other them. Ft. Detrick Lab technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jenny Ouellette ည Stanislaus Doiron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Taney Avenue, Frederick, Maryland Steve Herring - son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 10-26-2011 Frederick, Maryland 4 Donation 5 Other (Specify) ture of Funeral Service Linses 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final emen Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Imjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Por Month Day Pregnant at time of death signed by the all be detached to detached Unknown g Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Schi Records, No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed should been s 24b. Were autopsy findings available 24a. Was an page 2 s has autopsy prior to completion of cause of death? 1 Yes 2 No certificate Yes **Division of Vital** the Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 DLN ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 2 🗌 No Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MI 60 0 21702 Name and address of person who completed cause of death (Item 230 (Type, Print) 32 Aegistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36245 State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Marie Harps October 0 2011 6:43 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Citizens Care & Rehab. Center Frederick Frederick 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 □ M 2 X F Hours Days Min 89 Yrs. 176-16-1595 Pennsylvania Director March Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director Frederick Frederick 1 X Yes 2 No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ Funeral 23a must | United States 21702 1900 Rosemont Ave. items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: 27 is marked other than "natural", traumatic event, the Medical Exa White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government Program Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I 2 Estella Riddell Rosco Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6332 Penn National Dr., Fayetville PA, 17222 of Health item 27 Kathly Buckley / Daughter or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 10/27/2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Stauffer Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sheek, or heart failure List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 2 🗆 No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

10

State

801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

712

OMO

Registrar's Signature

Please Type or Printin Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 36246 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2011 Robert Larry Hilditch 8:19 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. (Month, Day, Year, 11/3/1947 Director 212-50-1732 63 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 X Yes 2 ☐ No MD Ceci1 Rising Sun 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 14 East Main Street, 21911 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filled within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Trash Hauler Trash Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph George Hilditch Agnes Bosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Reed - sister Woodside Rd. Conowingo, MD 21918 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 11/3/2011 Churchville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, PA 111 S. Queen Street, Rising Sun, MD 21911 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Rinal Onset and Death Physician/ nyocasala disease or condition Medical resulting in death) Due to o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown has been signed to the second 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate 2 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ျ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this of funeral dire 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours area co...

To the Funeral Director: After Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident ☐ Acciden
 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie October 30, 2011 completed cause of death (Item 23a) (Type, Print) te 31. Date filed 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 2011 21. tam alvin /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days FL 263-86-8482 62 Director 10- 18-1949 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 □ No Director MD Prince George's Beltsville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code 20785 3112 Craiglawn Road Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Never Married 2 Married XYes Yes, Give 2 No 1 ☐ Yes 2 ☐XNo Specify Specify: Black ò 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Private Security/Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew James Hamilton Mary Alice Wearing ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Monique Stephens/Daughter 9076 Hardesty Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other a 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other pla Maryland Veterans 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans 10/28/2011 Cheltenham, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 4 Donation 5 Other (Specify 21. Signature of Funeral Service Lice 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike, Forestville, MD 20746 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebra 1 Herniation Y Days /Medical Due to (or as a consequence of) **Examiner** 4 Days Stroke Schemic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of, or Attending Physician: The law requires that the death certificate be executed physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) detached i 9 Unknown 9 🔲 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? ate has 2 □ No 1 TYes 2 XNO 1 Tyes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☐ No 1 Ampatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: After it completely filled in by the funer Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) OCHEN 4940 Eastern Avenue, Baltimore, MD, 21224 MD '32. Registrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Knowles-Stogoski 22, 2011 Patricia Т. October 4:52 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Min. Hours Sept. 1, 1933 Director 78 014-26-4110 MA Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any inJury or other traumatic event, the Medical Examiner must be notified at any inJury or other traumatic and any inJury or other traumatic event, the Medical Examiner must be notified at any once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes ZXX No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4306 Knowles Avenue 20895 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 White 1 Tes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Eduart Todd Marguerite Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Stogoski/Husband 4306 Knowles Avenue, Kensington, MD 20895 Date 9, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery Dec. 2011 Arlington, VA 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD23a. Part 1. Inter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Lung Cancer Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending phy IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎦 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy performed Yes 2 death?
1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖺 No ျ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 🖾 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A the Accident Investigation 3 🔲 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 28f. Location (Street and Number or Rural Route Number ☐ Homicide determined City or Town, State) Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D65729 October 24, 2011 30. Name and address of person who completed cause of death (Item Farzad Malekanian, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year)

OCT 25 2011 State Registrar's Signature rack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36250 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 22 201^Yf^{ai} 07:15pm м Mary Kiss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Heritage Harbour Health & Rehab. Center If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year Hours 143-14-2143 **Director** 1 □ M 2 X F 02/28/1924 Massachusetts 87 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location at Director Examiner must be notified 1 Yes 2 X No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? items 23a Funeral 21035 United States 895 Gallant Fox Lane death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian rmed Forces?

Yes 2 XNo Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates White "natural", 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home 12th Homemaker Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve 2 Annie Zemyan Ignatz Logayda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 895 Gallant Fox Ln., Davidsonville, MD 21035 Mary Ellen Kiss/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Cemetery 10/26/11 Davidsonville, MD 21. Signature of Foreral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mul+1545cm Due to (or as a consequence of): Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions. Due to (or de a consequence or) cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Aortic Stanosis Division of Vital Records, HTN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Afib Hyperlipidenuo 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2X No Hospital: Other: 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury 1X Natural Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10/24/2011 R177898 Name and address of person who completed cause of death (Item 23a) (Type, Print) 200

Registrar DHMH 17 Rev 06-2011

State

Idal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month t 27, Physician/ Thomas Keith 2011 Dct 10:51 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5602 Lockwood Road Cheverly Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 🖾 M 2 🗆 F Months 85 037-14-9465 Director 18, 1926 Pawtucket, RI April Usual Residence of Decedent 28a-f show J Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10b. County with the Maryland 10a State 10c. City, Town or Location 10d, Inside City Limits Director Cheverly Maryland Prince George's 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5602 Lockwood Road 20785 USA death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3 Widowed 4 Divorced WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Civil Service Administration Office of Personnel (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Be 17. Father's Name (First, Middle, Last, 18, Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည Eaden Keith Nora Fogarty permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline A. Keith / Wife 5602 Lockwood Road, Cheverly, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Metropolitan Crematory 10/28/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? that the death ģ Day Month Year Pregnant at time of death the Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hyperlipidemia, Prostate Cancer 1X Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? Osteoprosis, Depression 24a. Was an autopsy perform med? 2♣ N 2 No Yes or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 \(\text{Yes} 2 🛚 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ₹ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer 1 K Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours hours

Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check

only one 29b. Signature and title of

> Thomas E. Maslen 7525 Greenway Center Dr, Ste 312, Greenbelt, MD 20770

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24

Medical

1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Oct 27, 2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D55559

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me,g921,11/09/2011dhb
Registrar

Registrar

State Of Maryland / Department of Health and Mental Hygiene
Per me,g921,11/09/2011dhb
Registrar 36252 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Levi Devilbiss Kontz PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Sep 20, Mary land 66 218-40-1140 **Director** 1945 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c, City, Town or Location Examiner must be notified at Director York Hanover 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral 17331 items 23a 1409 Wanda Drive USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 If Yes, Give 1 Never Married 2 Married ^{2 □ No} 1966-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced 1972 white Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Town of Manchester Maintenance 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Ruth H. Kontz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria M. Kontz, wife 1409 Wanda Drive, Hanover, PA 17331 or other 20b. Place of Disposition (Name of South) Agreematory or other place)
Carroll Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/14/2011 Winfield, MD injury 4 Donation 5 Other (Specify) 21. Signature of Eqneral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTIC Physician disease or condition resulting in death) Medical Due to (or as a consequence of): GRAM NEZATIVE BACTEREMIA Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Que to for as a consequence of NEUMONH The law requires that the death certificate be executed attending physician and for use as the burial-tran ON APPROVED BY MEDICAL EXAM! that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIDNEY INJURY 1 Tyes 2 No 3 Probably 4 Unknown ISCHEMIC CAPDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 X Yes 2 100 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Beath 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30263 WJL 5+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS CHOO ND ZOO METWORIAL WESTMINSTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 18 201 Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.															
			For State	S	State of M	arylan					nd Me	ental Hy	giene'	201		36253
			Registrar 1. Decedent's Name (First, Manual Control of the Contro	Aiddle Loot)			Ce	rtitica	te of L	Death		2. Date of De	Reg. No	201	1	
П	Physicia	ın/	Daniel Char		zorchic	·k					1	Month Ctober	Day	y 2011		3. Time of Death 12:45 a ^M
,	Medio Examin		4a. Facility Name (if not institu					4b. Cit	y, Town, or	· Location of I		CLODEI		County of De	ath	12.45
2	,		Suburban Hos	spital				Ве	theso	la				Montg	ome	ry
	Funeral Director		5. Social Security Number 185–16–9721		2 🗆 F	e (In yrs. Ia 86	as <i>t birthd</i> ay) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hours		8. Date of Bi $\mathbf{e}^{(Month}_{\mathbf{c}}$	rth ay, Year) 9	24	Birthpla Co <i>untr</i> y	ace (State or Foreign
	nd how at	=	Usual Residence of Deceder 10a. State 10b. Co			10c. City	, Town or Lo	cation			-			-	100	d. Inside City Limits
	larylar 3a-f s ified	ecto	MD N	Montgome	erv	· ·	Bethes									1 ☐ Yes 2X No
	the N or 20		10e. Street and Number					10f. Z	ip Code				10g. Cit	izen of What	Countr	y?
	n with	Funeral Director	8004 Park ()verlook	Drive				0817					SA		
21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show te other than "natural", or items 25a or 28a-f show ite event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 ☑ 3 □ Widowed 4 □ Div	Married	Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No				ispanic Origir n, Mexican, F Specify:	n? (Speci Puerto Ri	fy Yes or No can, etc.)		14. Race - An Black, Wh Specify: Wh	ite. et	С.
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121	thin 7	mo;	Elementary/Seconday (0-		College (1-4 or 8		Ìife. E	OO NOT u	se retired)					Todowo	1 0	aa.wnman+
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lan	l be fil lental rked o	ပ္	Michael Jo	seph La	zorchic	k						0rszu				
Maryland	of Health and Mental File of Health and Mental Fitem 27 is marked of other traumatic ever	100	19a. informant's Name/Rela	tionship (Type, F	Print)		19b. Maili	ng Addre	ss (Street a	and Number	or Rural i	Route Numb	er, City or	Town, State,	Zip Co	de)
Σ	nd 2 s ealth m 27		Grace Dunn La	zorchic	k/Wife		8004	Park	0ver	1ook I	Driv	e, Bet	hesd	a, MD	208	17
Baltimore,	ge 1a t of H If ite or oth		20a. Method of Disposition 1 Burial 2 Cremi	ation 3 ☐ Rem	oval from State		lace of Dispe emetery, cre	osition (Na matory or	ame of other plac	:e) 0	Da Oct.	27.	1	ocation - City		
ij	permit. Page 1 a Department of I Important: If ite any injury or ot		4 Donation 5 Ot 21. Signature of Funeral Ser			Meti	copoli			tory	201	1		andria		7A
Ba	perm Depa Impo any i		21. Signature of Funeral Ser	A A A	rein (2	F:	ranci no II+	S J.	Colli	ns F	unera.	1 Hon	ne Inc.	no.	MD 20901
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	Ph_sician/		shock, or heart failure. Immediate Cause (Final disease or condition		Cardior		atory	Arre	st							nterval Between Onset and Death
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	ian and arrial-transit		that initiated events resulting in death) Last	с	Due to (or as		,								\top	
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Box 68760	ath for	Physician/Medical	23b. Was decedent pregnan in the past 12 months?		If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Feta	I death 3	Ectopic Other		у			1	23d. Date of Month		y Day Year
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Division of Vital Records, P.O.	The law requires that the deatate has been signed by the apage 2 should be detached	þ	Part II. Other significant co	nditions contrib	uting to death b	out not resu	ulting in the	underlying	cause giv	en in Part I.		1				cause of death?
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<u>~</u>	an; Th tificate or, pa	Be Co	25. Was case referred to me	dical					26. Pl	ace of Death	(Check c		2 X N	0 1 📙 🗅	res 2	No No
Vit	Physician; r this certific ral director,	To B	examiner? 1 Yes 2 X No	Hosp	ital: 1x Inpat	ent 2 🗆	ER/Outpatie	nt 3 🗆 [Othe	er.			idence 6	S ☐ Other (Sp	ecify)	
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sior	Attending ar death. ector: After by the fune	Certificate:	3 🔲 Suicide 6 🗆 C	ould not be	8e. Place of Inj	iny - At hou	me farm st	M reet_facto		Yes 2 N	_	Rf Location	(Street an	d Number or I	Rural F	Route Number,
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	To the Hospital or Attendi Within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Medical	(Check 2 U Med		On the basis of e	xamination	and/or inves	stigation, i	n my opinio	on, death occu	urred at th	ne time, date	and place	e, and due to th	e caus	se(s) and manner stated.
	o the	Ž	only one) 3 L Cert 29b. Signature and title of ce	ifying Nurse Pra ertifier	actioner: To the	best of my	knowledge,		urred at the		and place,	and due to t		s) and manner te signed (Mo		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No. 20 | |

	1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2011 36254										
	Physicia Medic		Decedent's Name (First, Middle, Last)	Sophie LE	EVY			Date of Deat	26, 2011	3. Time of Death 3:10 P M	
	Examin		4a. Facility Name (if not institution, give street Potomac Valley Nursi]	4b. City, Town, or Loca Potomac	ation of Death		4c. County of Dea	nery	
	Funeral Director		5. Social Security Number 6. Sex 1 M	2 X F 7. Age (In yrs. Ias	st birthday) Yrs.		Under 24 Hrs. ours Min.	8. Date of Birth eb. 49,	1917 New	rthplace (State or Foreign	
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Loc	ation		<u> </u>	-	10d. Inside City Limits	
	ne Mary or 28a-1 notifie	Direc	Maryland Montgomery 10e. Street and Number		Potom	aC 10f. Zip Code		1	0g. Citizen of What C	1 🗆 Yes 2 💢 No	
	s 23a c nust be	Funeral Director	12708 Steeple Chase	Way		20854			United S	ta tes	
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	14. Race - Am Black, Whi Specify: W							
215-0	רסט 72 הסט : an "natu Medica	Completed	15. Decedent's Education (Specify only highest grade co	16b. Kind of Business lome Impro	vement/						
121	d within dygiene ther th nt, the	Be Co	17. Father's Name (First, Middle, Last)	college (1-4 or 5+) 4	Busi	nesswoman	Mather's Name		Carpet Majden Surname)		
/lanc	d be file Mental I arked o aric eve	To E	Morris Fri	edman		10.	Fannie	Metlits	sky		
Baltimore, Maryland 21215-0036	12 should alth and N		19a. Informant's Name/Relationship (Type, Pr Lynne Slud, Daughter	rint)	12708	Steeple Cl	hase Wa	Poton	City or Town State Z nac, MD 2	0854	
ore,	ge 1 and of Hez if item or othe		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Remo	oval from State C6	emetery, crem	sition (Name of atory or other place)			20c. Location - City o		
altin	rmit. Pay partmer portant y injury ce.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature — Juheral Selvice Littensee	Mt.	mo To	on Cemetery Metrinskysski	etrew F	uneral H	<u>Adelphi,</u> Home		
Ω	8 8 1 6 6	ngton, DC	20012 Approximate								
	Physician/	,	Interval Between Onset and Death 1 week								
	Medical Examiner		resulting in death)	Due to (or as a consequence Stroke						4 months	
	g 70 ₂	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Imjury	Due to (or as a conseque	ence of):						
	icate be executed physician and sthe burial-transit	I Exa	that initiated events c. — resulting in death) Last	Due to (or as a consequent	ence of):						
760	icate be physici s the bu	ledical	d								
Box 68	ath certif attending for use a	Physician/M	in the past 12 months?	f yes, outcome of pregnar Live Birth 2 Fetal Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year	
P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contribu	uting to death but not resu	ulting in the u	nderlying cause given ir	n Part I.			to the cause of death?	
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Reco	Physician: The law this certificate has al director, page 2	Comp						autops perfor 1 \(\sum \) Yes	med? death?	o completion of cause of	
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No Hospi	tal:		Other:	of Death (Check				
Division of Vital Records, P.O.	I or Attending Phys after death. Director: After this I in by the funeral di	Certificate: To		1 ☐ Inpatient 2 ☐ I 8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?			ence 6 Other (Spe ow injury occurred	ciry)	
)ivisi	il or Atte after de Directo d in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - At hor building, etc. (Specify)		et, factory, office		28f. Location (St City or Town	reet and Number or Fi n, State)	ural Route Number,	
<u>ں</u>	To the Hospital within 24 hours a To the Funeral C completed filled	ledical	29a. Certifier (Check conly one) 3 Certifying Physician Certifying Physician Certifying Physician Certifying Nurse Pra	on the basis of examination	and/or invest	igation, in my opinion, de	eath occurred at	the time, date ar	d place, and due to the	e cause(s) and manner stated.	
	To the within	Σ	29b. Signature and title of certifier	-Q () n :	On a	29c. License nun D382	mber		29d. Date signed (Mor	th, Day, Year)	
			30. Name and address of person who comple			rint)					
	Sta	te	Dr. A. Mendhirat 31. Date filed (Month, Day, Year) OCT 28 2011	ta 2401 Res	search	Blvd., Sui	ite 330), Rocky	<u>rille, Md.</u>	20850	
	Registra	ar	UU 20 ZUI	(bush 6	1. 1494						

	Amend #23a per CNP Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Dept. 10–26–11 KAH State of Maryland / Department of Health and Mental Hygiene 20 36255													
		•	For State Registrar	State of M	aryland	d / Depa Cer	artmen <i>tificate</i>	e of C	leaith and Death		Reg. No		-	
	Physicia	in/	1. Decedent's Name (First, Middle, Last) Frederick H. Lamar	+in						2. Date of De Month October		4 20¶		ime of Death :07 A M
an industry	Medic		4a. Facility Name (if not institution, give str				4b City	Town or	Location of Dea			County of De		.07 A W
	Examin		Heritage Harbour Health		Center			apo1				Anne Ar		1
	Funeral		5. Social Security Number 6. Sex		je (In yrs. la	st birthday)	If Under Months	_	If Under 24 Hr Hours Mir				irthplace (State or Foreign
	Director			M 2 □ F 8	8	Yrs.	WIOITIIS	Duyo	Tiodis I IIII	1/18/1			w Jei	sey
	nd thow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. In:	side City Limits
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Maryland Anne Arur	ndel		Annap	olis 10f. Zip	Code			10a Cit	izen of What (☐ Yes 2 😿 No
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	eath v tems er mu	Fun	11. Marital Status	2. Was Decedent	Ever in U.S	. 13. \	Nas Deced	dent of Hi	spanic Origin? (Specify Yes or No-	.]	14. Race - Am		lian,
36	11. Marital Status 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Never Married 3 Never Married 1 Never Married 4 Divorced 1 Never Married 5 Never No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 5 Never No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never No- If Yes, specify: 1 Never No- If Y													
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	h _y sician/ Medical Examiner	ner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		e. i 5\ a conse l l Fil	Sky ence of): orill	0	rqc	^	ac or respiratory a	rrest,		Inter Onse	oximate val Between at and Deat
09289	ificate be executed g physician and as the burial-transit	Aedical Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as	a consequ	ence of):								
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o u	iding th: : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	ıy, Year)	injury	м	work	? Yes 2 \Begin{array}{c} No	20d. Describe	now inju	y occurred		
Division of Vital Records,	l or Atter after dea Director:	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et			eet, factory	y, office		28f. Location (City or To		d Number or I	Rural Route	e Number,
	e Hospita 124 hours e Funeral sletely filler	Medical	29a. Certifier (Check (Check only one) (Certifying Physici one) (Certifying Nurse leaves)	r: On the basis of	examination	and/or inves	tigation, in	my opinio	on, death occurre	ed at the time, date	and place	e, and due to th	e cause(s)	and manner stated.
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-	axl		30. Name and address of person who con					1000	Dr ^	nnapolis	MD	21401		
	Sta	te	Stephanie Porter, 31. Date filed (Month, Day, Year)	32. Pegisti	ar's Signat			TOHY	υι., A	maports	, 1111	21401		
	Registra		OCT 2 6 2011	Dru		1. h	alle	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:20A Diamond Lee Lucente October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Edgewater 320 Hamlet Circle If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 216-40-9269 1 🗆 M 2 🛣 F 69 12/26/1941 Washington, DC Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Edgewater Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21037 320 Hamlet Circle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 in and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ercoli Boccabello Mary Dagres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Hamlet Circle, Edgewater, MD 21037 Frank A. Lucente/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State akemont Mem'l Gardens 10/28/2011|Davidsonville,MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 23a Part 1. Enter the disease, or complications that a sed the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition Physician/ UNKNOWN PEIWARY MERGERIA CANCER Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or in that initiated events and-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria the buna Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day ed by the a g Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital: Other: 1 🗌 Yes ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No s after death Accident Investigation 6 Could not be Suicide within 24 hours after dex To the Funeral Director completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur

State Registrar

10,

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alberta Mae Lewis October 25,2011 3:35 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 01/06/1923 Hours Director 577-28-6034 1 M 2 KF 88 Wash.,D.C. ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Md. P.G. 1X Yes 2 No Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4709 Addison Road 20743 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Yes, Give Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Family and Elementary/Secondary (0-12) College (1-4 or 5+) Child Services 1 year Administrative Assistant Be 17. Father's Name (First, Middle, Last)
William Holley 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ဂ္ Sadie Henson and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Cecelia Lewis/Daughter 4709 Addison Rd., Capitol Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc Beltsville,Md 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.F., Washington, D. 21. Signature of Funeral Service Licenses Cran 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Failure to Thrive Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End Stage Dementia Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 5 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tit 29d. Date signed (Month, E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington, D.C. 20017 Kathy S. Brenneman M.D. 1160 Varnum St., N.E. 31. Date filed (Month, Day, Ye State OCT 3 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 24. 2011 Etta Barclay Meck 0415 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Manor Healthcare Center Cecil Rising Sun Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months April 21. 1917 216-52-7768 1 M 2 X F Hours 94 Director Pennsylvania Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Maryland Cecil Perryville 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 918 Mill Creek Avenue U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Perryville News Stand (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
Ten Years College (1-4 or 5+) Perryville, Maryland Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allison Barclay Helen Shaub .. Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole A. Loveless (daughter) 164 North East Isles, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) St. Mark's Cemetery 10/27/11 Perryville, Maryland 21. Signature of Funeral Service Liber ^{22. Name and Address of Facility} Lee A. Patterson & Son Funeral Home, P Perrvville, Maryland 21903-0766 Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ amary arton Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any leading transcribed cause. Enter Underlying Cause (Disease or iinjury Examiner I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe prior to completion death? certificate 2 1 1 Yes 25. Was case referred to medical Be 26. Place of Death Check only one) examiner? ၉ 1 Tyes 2 1 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check within 2 To the F 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifier 29d. Date signed (Montin, Day, Year) O ZA

DHMH 17 Rev 7/2009

State

Registrar

31. Date flied (Month

Day, Year)

OCT 28

(0)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	Pleas			nd / Depa	artment of F artificate of L	lealth :		lental Hy		20	bie.	36259
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Funeral Director		5. Social Security Number 475–18–066	ber 6	. Sex 1 □ M 2 🏋 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 6/25/1	y, Year)	1	Count	olace (State or Foreign try) esota
faryland 3a-f show tified at	ector		ob. County Anne A:	rundel	10c. Ci	ty, Town or Lo	cation apolis		I	0, 23, 1				0d. Inside City Limits 1 ☐ Yes 2 🔀 No
s 23a or 2 s ust be no	Funeral Director	10e. Street and Number 84 01d Mil	er		#106		10f. Zip Code 214	09			10g. Ci	itizen of W		try?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 3 Widowed 4		Armed Fo	е		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ሺ No	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race Black Specify:	, White, e	
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permi Depar Impo any ir		21. Signature of the	lee				2. Name and Address 2973 Solo	mons	Isla	and Rd.	Edg			
Physician/ Medical Examiner	Examiner	Immediate Cause (Findisease or condition resulting in death) Sequentially list conditions if any, leading to immediate. Enter Underlying the sequence of the conditions of the cause.	allure. List onl al tions, adiate	a. Due to	ch line.	uence of):	er the mode of dyin	/	/ \				>	Approximate Interval Between Societ and Death
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Physicia this certi	: To Be	examiner? 1 Yes 2 2		Hospital: 1 28a. Date	Inpatient 2	ER/Outpaties	nt 3 🗆 DOA Othe	4 ∐ Nı	ursing Ho	me 5 Resi			(Specify)	Living
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certificate:	Natural 5	Pending Investiga Could no	tion t be 28e. Place	th, Day, Year)	injury ome, farm, str	work			28d. Describe h	Street an	nd Number		Route Number,
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vitl To	<	29b. Signature and title	Men	HAD			29c. License	number 337	5		10/2	ate signed	(Month, I)ay, Year)
62		30. Name and address KANDN W	of person wh	001 283	6 8m	TH AVE	SUITE Z	203/	SAZ	TMON	Mi)21	20	9
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TOW ARD Menth MINITER ONAM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1127 Mainsail Dr. Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Hours Min Month 1/24/1934 77 Connecticut 104-28-4337 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 1127 Mainsail Dr. 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried "natural", or ģ 1 X Yes 2 No If Yes, Give Retired Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Captain US Navy Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Rose permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Howard E. Miniter Gerster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace P. Miniter/Wife 1127 Mainsail Dr., Annapolis, MD 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Lakemont Mem'l Gardens 10/31/2011 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of Funeral Service Licenses ala 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ E disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal Geal
Pregnant at time of death 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 L 3 L only one) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) NNAPOLISMAMYOU 747 (W) CAT 31. Date filed (Month, Day, Year) strar's Signature State OCT 2620 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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						Cer	tificate of	f Death		F	Reg. No.	11	, , , .
			1. Decedent's Name (First, Middle, La	ist)					2	Date of Dea			Time of Death
	Physici		George H.	MCCAIG					(Month	Day 20	11	1,50 PM
1	/Medic		4a. Facility Name (If not institution, give		-			4b. City, To	wn, or Loca	tion of Death	4c. County		
1.	Examir	ier	Villa Rosa Nursi					Mitche	117711	1e	Princ	e Georg	ge's
			5. Social Security Number 6. S		(In yrs. las	t birthday)	If Under 1 Yea	ar If Under		. Date of Birt (Month, Day		9. Birthplace	(State or Foreign
	Funeral Director		,	1⊠M 2□F	90	Yrs.	Months Day	s Hours	Min.	Month, Day eh. 26	, Year) 5, 1921	Country)	. MA
	Director		219-07-9956 Usual Residence of Decedent		70					001 20	,, 1,11		,
	land		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. I	nside City Limits
	Many f sh	ō	MD Prince (Ceorge's	Co114	ege Pa	ark					1	X Yes 2 No
	28a	ec.	10e. Street and Number	Scorge o	OOTI	-60 10	10f. Zip Code				10g. Citizen of W	/hat Country?	
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	be filed within 72 hours after death with the Maryland tall Hygiene. In a natural, or items 23a or 28a-1 show event, the Medical Examinar must be notified at	by Funeral Director	4703 Mangum Road	12. Was Decedent B	Ever in LLS	12 1	20740 Was Decedent of	f Hispanic Ori	ain? (Speci	fv Yes or No	14. Race	USA - American Ir	ndian,
	er de	Š	11. Marital Status	Armed Forces?			f Yes, specify Cu	ban, Mexican	, Puerto Ri	can, etc.)		k, White, etc.	
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Maryland	01 02 00 20		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Stre	et and Numbe	er or Rural I	Route Numbe	er, City or Town,	State, Zip Coo	de)
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Baltimore,	oth oth		20a. Method of Disposition	3 -	20b. Pla	ce of Dispo	sition (Name of natory or other p	olace)		Date	20c. Location -	City or Town,	State
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Ξ	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lice	nsee		22	2. Name and Add	ress of Facilit	ty		/ 700 D	161	Λ
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			23a. Part1. Enter the disease, or com	Inacha	Carri								MD 20781 proximate
			shock, or heart failure. List only	one cause on each lin	ine death. ie.	Do not ent	er the mode of d	lyllig, such as	Cardiac or	respiratory a	11651,	Inte	erval Between set and Death
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Cereb	NUa	scul	ar V	15ea 2-6					
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P.O. Bo	0 0	Physician	Part II. Other significant conditions	contributing to death bu	ut not result	ing in the u	nderlying cause	given in Part I	I.	23b. Did	tobacco use co	ntribute to the	e cause of death?
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	741		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,	Print)	C	h -	-	Octobe elt mon	^^ .	
	111		Dorothy Sea	ymd 2	8355	SWY	In three	rue D'	K 40.	5 to	eltron	e, Mid	51509
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARGARET MARIE NORTHERN OCT. 2^{Da} 20°11′1 9:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY CASEY HOUSE HOSPICE ROCKVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 V F Days Months Hours 91 577-16-1453 04/04/1920 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 No MONTGOMERY POOLESVILLE MD 10e. Street and Number ò 10f. Zip Code 10q. Citizen of What Country? Completed by Funeral 23a 16911 HOSKINSON ROAD 20837 USA 12. Was Decedent Eyer in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PEOPLES DRUG BOOKKEEPER 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ၉ GRACE ROSE MILLER HARRY OTHA MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16911 HOSKINSON RD., POOLESVILLE, MD 20837 BARBARA POLAK / DAUGHTER 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/2011 PARK HEAD CEMETERY BIG POOL, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition COPD Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of illipity that initiated events Due to (or as a consequence of): death certificate be executed resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ LUNG MASS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending s after do. al Director: Afte 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D37142 OCT. 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEOFFREY COLEMAN, MD1355 PICCARD DR., SUITE 100, ROCKVILLE, MD 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Day 2011 1304 William H. Parker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 215-26-0404 Director 1**X** M 2 □ F 1925 Maryland 16 86 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Lothian 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20711 USA 90 Old Solomons Island Rd. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Narried 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2X No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed should be filed with and Mental Hygien is marked other to 6th 0 Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Parker Agnes Brown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Parker(Wife) Old Solomons Island Rd. Lothian, Md. 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 10-29-11 Lothian, Md. Adams U.M. Church 4 Donation 5 Other (Specify) 柳mene aRee ese F& ilitSons Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ Ou Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I d be det δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and on infectigation, many specific and place and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month,

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

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Records,

Division of Vital

DHMH 17 Rev 06-2011

30. Name and address of per

Date filed (Month, Day, Year)

OCT

n who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 23 Physician/ 2011 3:27 P M David Michael Pielmeier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) **Funeral** May 10 Hours Washington, 1940 577-54-6643 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral USA 21403 3533 Cohasset Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College (1-4 or 5+) the Navy Electrical Engineer years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Madeline Cecilia Trexler Eugene John Pielmeier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3533 Cohasset Avenue, Annapolis, Maryland 21403 Patricia L. Pielmeier/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10/29/11 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal r. of Funeral Sofvice License 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a con-equence of): Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or liniury signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an las l prior to death? autopsy performed certificate ! 1 Yes 2 No 1 ☐ Yes 2 ☐ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: မ 1 Tes 1 Appatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

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31. Date filed (Month, Day, Year) OCT 26

<u>Judy H. Joseph</u> Herbert,

State Registrar

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32 Registrar's Signatur

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/ Medical Examiner Carmen Anthony Perry 4a. Facility Name (if not institution, give street and number) 523 Monterey Ave. Superal 5. Social Security Number 6. Sex 7. Age (in vrs. last birthday) If Under 1 Year 1 If Under 24 Hrs. 8. Date	of Death th Day 22, 2011 4c. County of Death	3. Time of Death 824pm M
Examiner 4a. Facility Name (if not institution, give street and number) 523 Monterey Ave. 5. Social Security Number 5. Social Security Number 6. Sex 7. Age (in vrs. last birthday) 15 Under 1 Year 16 Under 24 Hrs. 8. Date	4c. County of Death	824pm W
523 Monterey Ave. Odenton Superal 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year I funder 24 Hrs. 8. Date		
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date	Anne Arunde	el
Director 176-32-1247 1 A M 2 D F 93 Yrs. Months Days Hours Min. (Mor	e of Birth hth, Day, Year) 9/1918 9. Birthpla Country	ce (State or Foreign ') PA
to the position of the positio	100	d. Inside City Limits
MD Anne Arundel Crownsville	10g. Citizen of What Country	1 Yes 2XXNo
Total State 10b. County 10c. City, Town or Location 10c. C	USA	y ·
Affined Forces?	or No- c.) 14. Race - American Black, White, etc Specify: White	2.
The state of the s	16b. Kind of Business/Indu	
(Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) College (1-4		otry
College (1-4 or 5+) Sgt. Major 18. Mother's Name (First, Middle, Last)	US Army	
Part of plants of the part of the plants of the part o		
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route I		de)
John Perry Son 994 Waterview Dr. Crowns 20b. Place of Disposition (Name of Date	ville, MD 21032 20c. Location - City or Tow	n, State
1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lakemont Memorial 10/28/20	11 Davidsonvill	e, MD
The part of the pa	12 Ridgely .	Ave. • MD 21032
shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	5	nterval Between
O9X09 The part of the part 12 months? The part 12	23d. Date of delivery Month D	y Yay Year
The part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	e. Did tobacco use contribute to the	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e	a. Was an autopsy prior to comperformed?	by findings available pletion of cause of
The spin of the sp		
To so the state of	Residence 6 Other (Specify)	
27. Mann of Death 1	ation (Street and Number or Rural R or Town, State)	Poute Number,
29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place and due to only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place and due to one of the date of the da	, date and place, and due to the caus	e(s) and manner stated.
29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to only one) 29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Da	
30. Name and address of berson who completed cause of death (tem 23a) (Type, Print)	I (de Barre	0 10 210
State Registrar OCT 2 6 2011 State Registrar	of our joint	1.094

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Dav Year 1:174 M George F. Powell 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Prince Georges Doctor's Community Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Sex 1 X M 2 D F Months Days Hours Min Jumph, Pay 1 950 61 Marvland 216-56-5415 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1X Yes 2 □ No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13401 Old Chapel Road 20720 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Montgomery Wards life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Worker Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Herbert Powell Harriet France 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13401 Old Chapel Road Bowie, MD 20720 Anne Powell/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crematory or other place) 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Huntt Crematory 10/25/2011 Waldorf, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 Signature of Funeral Septic any in once. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ Dysrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in july that initiated events Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy perform 2 No To the Hospital or Attending Physician: 25. Was case referred to medica To Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🗌 Yes 5 Pending 2 🗌 No within 24 hours after death. To the Funeral Director: A Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie MOD54675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD LAWYERE MS AKOKA SHOBHIT 31. Date filed (Month, Day, Year) State OCT 2 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ M THOMAS HENRY RAKES, JR. 10/25/201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 8. Date of Birth 7. Age (In yrs. last birthday) Sex 1X M 2 □ F **Funeral** Days Hours Min. 01/16/1927 **Director** 224-24-8774 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No MD Gaithersburg Montgomerv 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Odenhal Avenue, #502 20877 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 XYes 2 No 1944If Yes, Give Black, White, etc. 1 Never Married 2 Married by 1 Yes 2 No Specify: Black 3X Widowed 4 □ Divorced Completed 1946 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Building Service Engineer Housing 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) 2 Thomas Henry Rakes, Sr. Eva Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Rainsborough Way, Columbia, SC 29229 Thomas H. Rakes, III/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Cremation Sv 10/31/2011 Hanover, MD 21. Signat to of Funeral Service kinens Snowden Funeral Home 22. Name and Address of Facility Horse moules 246 N.Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory
Due to () as a consequence Fai Ph sician/ days Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the buria - to Due to (or as a consequence of) attending physician a Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the at d be detached for Yes 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à and 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed cate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestiv autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Hospital Other: ပ 1 € Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1-Natural 5 Pending work r 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 🔗ifi 29c. License numbe 29d. Date signed (Month, Day, Year) Detober D20148 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Garthersburg Dolinsky Russell MD -911 Avenue, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 201 OCT Registrar

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Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

larivel Robles	State of Maryland / Department of 1-For State Registrar Certificate of	Dooth	eg. No. 2011 3626								
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)	2. Date of Dea Month October 2	Day Year								
	4a. Facility Name (if not institution, give street and number) 43520 Pear Tree Ct #12	o. City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Bir	rth(MM/DD/YYYY) 9. Birthplace (State or								
Director	589-47-4758 _{1 M 2} K _F 45 Yrs.	Months Days Hours Min. 12/4	/1965 Foreign Country N.Y.								
any .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n	10d. Inside City Limits								
Maryland 28a-f show d at once. ector	MD Montgomery Silver S		1 Yes 2 No								
th the Maryland 23a or 28a-f sho notified at once.	3520 Pear Tree Court #12	20906	USA								
15-0036 filed within 72 hours after death with the Maryland I Hygiene. Ad other than "natural", or items 23a or 28a-f she t, the Medical Examiner must he notified at once © Completed by Furneral Director		as Decedent of Hispanic Origin? (Specify Yes or No- es, specify Cuban, Mexican, Puerto Rican, etc.) Puerto Rican White									
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72 houn	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use retired)									
15-0036 filed within 72 hour Hygiene. d other than "natu the Medical Exam the Medical Exam or Completed.	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	None Maiden Surname)								
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur e event, the Medical Exam To Be Completed It	Pedro Robles	Margaret Cru									
shoul shoul	19a. Informant's Name/Relationship (Type, Print aughter 19b. Mailing Marlene Vazquez Robles/ 137 M		r Darby,PA.19082								
ore, M ges 1 and 2 t of Health if item 2 ther traum	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposi crematory or oth Chesapea	ion (Name of cemetery, price of cemetery, er place) . Ke Crem . 10/29/201	20c. Location - City or Town, State 11 Beltsville, Md								
Baltimore, MI permit. Pages I and 2: Department of Health a Important: If item 27 injury or other traum	4 Donation 5 Other Specify:										
Physician	21. Signature of Funeral Service Ligenses 22 harmonic policy of Funeral Service Ligenses 22 harmonic policy of Funeral Service Service 9241 Columbia Blvd.Silver Spring 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart A										
Medital Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Pulmpnary Thromboembolism										
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8760, tificate be ng physici as the buri	IF FEMALE: 23b. Was decedent pregnant in the 22c. If yes, outcome of pregnancy 1 Live birth 2 Fet	al death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year								
b. Box 6876, the death certificate by the attending phy ched for use as the by Physician/M.	Progress of time of death	er (Specify)									
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Division of Vital Records, talor Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed			psy prior to completion of cause of death? 2 No 1 Yes 2 No								
ital Recision: The certificate ecetor, page	25. Was case referred to medical examiner? Hospital: Inputient 2 FR/Outpatient	26.Place of Death (Check only one)									
n of Vit sing Physic After this funeral dirt	27. Manner of Death 28a. Date of Injury 28b. Time of Ir		Residence 6 Other: Scene how injury occurred								
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Division o ospital or Attending hours after death. Inertal Director: After y filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	t, factory, office building, etc. 28f. Location (or Town, \$	Street and Number or Rural Route Number, City State)								
24 July 19 Jul	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurring one) 2 Medical Examiner: On the basis of examination and/or investigation.										
To the within To the comple	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
-	2-20-	O.C.M.E.	October 23, 2011								
	30. Name and address of person who completed cause of death (Item 23a) DDnna M. Vincenti, MD Assistant Medical Examiner 900	W. Baltimpre Street, Baltimpre, MD 2	1223								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER Physician/ 2011 24 8:00 Рм STANLEY GERTRUDE WILSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth **Funeral** Days Hours June 14, 1914 1 M 2 X Maryland 97 219-36-7656 **Director** Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director 28a-f 1 X Yes 2 No Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r ö Funeral U.S.A. 21703 5651 Sandy Court ural", or items a permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces? ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) 5+Teacher School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosa Boyer Grover Μ. Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 Damascus, Maryland 28001 Kemptown Church Road, Phyllis S. Walker - Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 10/28/2011 Damascus Cemetery Damascus, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Licenses 20872 6401 Ridge Road, Damascus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed -tran that initiated events resulting in death) Last and Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy Yes 2 this certificate **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Aftert injury Natural 5 \square Pending work?
1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month Day, Year)

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MI)

Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

65183

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 26 per med cert 6921nk, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ HIV Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 6. Sex 7. Age (In vrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Month: Hours Min (Month, Day, Year) **Director** 79 175-26-1743 Usual Residence of Decedent 28a-f show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No MD Queen Anne's Centreville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 501 Chesterfield Ave. 21617 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes XX No Black, White, etc. 1 Never Married XX Married Completed by Maryland 21215-0036 White 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 4 Public Relations Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Sheppard Mary Duricko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Chesterfield Ave. Centreville, MD 21617 Beverly Sheppard Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place) 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/24/2011 Glen Burnie, MD 21. Signature of Funeral Service Lipers 22. Name and Address of FacilitHardesty Funeral Home, P.A. For 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final Physician/ 103 piratue tcute disease or condition Medical resulting in death) Due to (or as a consequence of) Examine iration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due for as a consequence of 1a 450179 that initiated events resulting in death) Last attending physician and Physician/Medical arkinson Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death signed by the a 1 ☐ Yes ≥ L ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STENOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has performed? Yes 2. No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Tyes 0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best manner as stated. (Check within 2 To the F 3 only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Regi trar's Signature State

Registrar

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month :35 PM Physician/ Medical DRIVE Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 586 CHNWOO Age (In yrs. last birthday 9. Birthplace (State or Foreign Country) Social Security Numbe 8. Date of Birth **Funeral** Davs Hours (Month, Day, 1 M 2 227-22-689 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a State 10c City Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 640 Mecklenberg Ave 21601 12. Was Decedent Ever in U.S Armed Forces 1 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 Yes 2 No Specify White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retired Seamstress Clothing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Adam Wicker Mary Alice Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3836 Park Lane Trappe, MD 21673 Angela Potthast/ Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Hill Memorial Park 10/28/2011 Lynchburg, VA 4 Donation 5 Other (Specify) . Signature of uneral Service Lice 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final BRAIN CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tohacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy page performed death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function is a second to the function in 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Gurtifying Nurse Practioner: To this best of my knowledge 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D0066409 10,22,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Registrar DHMH 17 Rev 7/2009

State

822

Registrar's Signature

CTAI

SUITE 301, EASTON, MD2160

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Michael Craig Walter Mantb - 29 - 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harkord Havre de Grace Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 60 Director 213-58-3700 Maruland 09-21-1951 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examination at the motified at 1 ☐Yes 2 No Directo Maryland Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UnitedStatesofAmerica 4114 A Webster Lapidum Road 21078 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary E. Reynolds Howard G. Walter 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mary E. Reynolds Walter (mother)

P.O. Box 66, Churchville, Maryland 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RA Ferris & Co Inc 11-01-2011 WestChester, Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 21. Signature of Funeral Bervice Prensi 1123 S. Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the dis. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 21 /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and physician al Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Matural 1 ☐Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one)

State Registrar

29b. Signature and title of certifier

within 2 To the

Aberdos

ss of person who completed cause of death (Item 23a) (Type, Print)

16 32 Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Marylan		tificate of l		and Menta	Reg					
			1. Decedent's Name (First, Middle, Last)				2. Date	of Death	21		3. Time Death		
	Physicia Medic		Martha S. Wright				0ctc	ber 2	Day 20, 20	11 11	8:30 A ^M		
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location o	f Death		4c. County	of Death			
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 2 Hours		of Birth th, Day, Ye	ar)	g. Birth Cour	nplace (State or Foreign		
	Director		524-26-6574 1□M2XF 82	Yrs.				/1929					
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	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		87 Bay Drive			403		1	USA		,		
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Baltimore, Maryland 21215-0036	permit. Page 1. Department of Important: If it any injury or of any injury or of once.		21. Signature of Fuller Service Licensee		Name and Address 973 Solo		_						
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>	Phys this ral di	<u>۲</u>	1 Yes 2 No Hospital: 1 Inpatient 2 2 27. Manne of Death 28a. Date of injury	ER/Outpatier	nt 3 L DOA	4 ∐ Nu	ursing Home	1	ce 6 U Other		f(y)		
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Division of Vital Records,	after Directory		4 Homicide determined building, etc. (Speci					or Town, S					
_	To the Hospital or Attending Physician: Th, law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has keen signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying Physician: To the best of my known	wledge, death	occurred at the tim	ne, date and	place, and due to	the cause	e(s) and mann	er as sta	ated.		
	n 24 n 24 ne Fu	Med	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of	ion and/or inves of my knowledge	tigation, in my opin , death occurred at	ion, death od the time, dat	ccurred at the time te and place, and o	date and plue to the d	place, and due cause(s) and n	to the c nanner as	cause(s) and manner stated. s stated.		
	Withi Comp		29b. Signature and title of certifier		29c. Licens	se number		290	d. Date signed	l (Month	n, Day, Year)		
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	10.		30. Name and address of person who completed cause of death (Ite			71							
	w				nse Hwy.	, #400), Annapo	olis,	MD 21	<u>401</u>			
	Stat Registra		31. Date filed (Month, Day, Year) QCT 2 6 2011	1. Jan	Kel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Word 3:30 PM 1. October Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death Laurel Regional Hospital Prince George's aure 9. Birthplace (State or Foreign Country) Selma Alabama 1 Year If Under 24 Hrs. **Funeral** . Age (In vrs. last birthday 8. Date of Birth Months Days Min. 1 □ M 2 🔽 7Ŏ Hours 03/09/1941 Director 027-30-9749 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified i 1 X Yes 2 No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 Westview Terrace 20708 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 IX No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🔀 No Specify Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Mason Mary White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a ht: If item 27 is y or other tra Karen E. Johnson/Daughter 1123 Westview Terr., Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/6/2011 permit. Page Department o Important: If any injury or once. 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory, Inc. Beltsville,Md 21. Signature of Funeral Service Licensee Property S. Washington & Sons Co., Inc. Mary 4925 Burroughs Ave., N.E., Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Per Kalemia Onset and Death Physician/ disease or condition resulting in death) Medical Due to or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 p 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes 욘 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certiff 29d. Date signed (Month, Day, Year) D69247 2 オーハ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road Mohamed M. Tourky.

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

OCT 3 1 2011

Laurel Regional Hospital

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 16:18 P.M M. GEORGE ALLEN /2011 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE, GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 214-12-8353 1 **№** M 2 □ F Hours WEST GERMANY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43rd STREET USA 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗷 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates Specify: BLACK 3 ☐ Widowed 4 🄀 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired MORGAN STATE Elementary/Seconday (0-12) College (1-4 or 5+) LANDSCAPER 12 INNVERSITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GEORGE J. ALLEN MARIAN JEAN BENNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SEDRGE J. ALLEN/FATHER, 917 E. 43rd ST. BATO, MD. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) LUVOON PARK CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 📈 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/18/11 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FINERIAL SCVS 21. Signature of Funeral Sevice Licenses NO1553 4905 YORK ROAD. BALTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death & RESPIRATORY FAILURE DUE TO MUCOUS PLUGGING FEW DAYS disease or condition resulting in death) B. RECURRENT MUCOUS PLUGGING REQUIRING REINTUGATIONS FEW DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury ANOXIC BRAIN INJURY FEN DAYS that initiated events resulting in death) Last Physician/Medical PLEURAL FFFUSION BILATERAL FEW MONTH RECURRENT 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant 9 Unknown Month 5 Other (specify) Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HTM, DM, ESRD ON HD PLEURAL EFFUSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? PERIPHERAL VASCULAR DISEASE 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Certificate:

burial-transi and attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Box 68760 P.O. signed by Records, peen has page 2 this certificate Division of Vital director. After 24 hours after death Funeral Director

Funeral

Director

28a-f show

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permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu.

is marked other than "natu aumatic event, the Medical

Department of Important: If it any injury or of once.

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21215-0036

Baltimore, Maryland

28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

RES 000

29d. Date signed (Month, Day, Year) 11/11/2011



filled in by

Medical

only one) 29b. Signature and title of cert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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SRITIKA THAPA BALTIMORE

31. Date filed (Month, Day, Year) NOV 15

32 Registrar's Signatur

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10 PM Physician/ Butler lohn Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** NH timo re Union HO5 emorial Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** (Month Day Year) 214-22-0639 Director 1 🗶 M 2 🗆 F Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State at Director "natural", or items 23a or 28a-f sl edical Examiner must be notified a 1 X Yes 2 No Itimore Ba MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 15 A 21218 401 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? δ 1 Neyer Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Black 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) Taxi the Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked of ပ Leona William Millburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter) Department of Health ar Important: If item 27 is any injury or other trau Marble Hall 4417 Rd # 258 Batte MID onnie 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest 17-14 22. Name and Address of Facility 21. Signatur- f Juneral Service Licensee AVENUE 222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Daw to (or as a nunsuculence of): Examine cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate has blirector, page 2 s death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 1. Natural 5 Pending 1 Yes in 24 hours area. In Euneral Director: Af 2 🗌 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. completely (Check within 2. only on 29d. Date signed (Month, Day, Year) 29b. Signatu gn ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

State Registrar

5

NOV

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36278 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 0534 M Drowning Medical not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico 156049 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 204.38.2986 Months (Month, Day, Year Director 1 □ M 2 F 11.27.1949 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director Yes 2 ☐ No 10e. Street and Number 10f. Zip Code Funeral items 23a 21853 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4 or 5+) DECTUR 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Hall 20a. Method of Disposition 20b. Place of Disposition (Name of ocation - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State SCIOLE 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee any MOZ1216 23a. Part 1 Inter le disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death UNG Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): nding physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the at detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Hospital or Attending Physician: The law autopsy director, page 2 this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 5 Pending injury X Natural 2 Accident
3 Suicide
4 Homicide 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 57952 M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

Records,

Division of Vital

504B

Milford ST.

32. Aegistrans Signat

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 94, 20 m Physician/ 0845 Mirta I. Bravo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, April 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** Hours Chile 1929 Director 215-13-7578 82 April Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at with the Maryland Director notified 1 Yes X No Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ö the Medical Examiner must be USA items 23a Funeral 20902 2919 Schoolhouse Court death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: If Yes Give Completed 3 Widowed 4 Divorced Chilena White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Bravo, Mirta Manager Department of Health and Mental Hyginportant: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Clemira Cid Beltran Arturo Bravo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2919 Schoolhouse Court Silver Spring, MD 20902 Mirtha M. Hurtado/daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial A Cremation 3 Removal from State Woodbine, MD Final Journey Crematory 11/14/11 4 Donation 5 Other (Specify) f Funeral Se 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ Cardiac OUTS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner isease Sequentially list conditions, it any tracing to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Nation 2 ER/Outpatient 3 DOA ျှ within 24 hours after death. To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No 1X Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Vovember 11, 2011 70144 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Cdr Dr Rockville, MD 9901 Michael Murran MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1

5450 O

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician:

sician and burial-trans attending | for use as signed by the a d be detached f page 2 s To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or Items 23a or

the Medical

Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, ionce.

Physician

/Medical

Funeral Director

Completed by

Be

2

MI

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 1 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Asadi, 1012 Follscroftway

32. Registrar's Signature

cal Examiner	Sequentially list conditions, if any, leading to in mediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a nonsequence of): Chronic Renal Fai. Due to (or as a consequence of): Failure to Thrive	lure
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Completed by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Whursing Hom	(Check only one) ne 5 ☐ Residence 6 ☐ Other (Specify)
ation: T	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
dical (ysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	

H0054424

InternelliMD 21093

29d. Date signed (Month, Day, Year)

11-14-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 8:50P M 201 OW Nov Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia 7575 F Weatherworn If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, 64 Director 1946 209-36-0425 Dec 03 Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland notified at Director 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 7575 F. Weatherworn Way 21046 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Was Deceded... Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 6 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify "natural", Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Department Systems Administrator Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Amelia Louisa Kaumann Chester Aubery Browne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Lee Phillips /Friend 9501 Thornknoll Ct. Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Nov Important: If any injury or 4 Donation 5 Other (Specify) Beltsville, Maryland 2011 Chesapeake Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph sician/ Cana disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause (Disease or iinjury Disaste for as a possessimine off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Year Month detached Unknown Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use ntribute to the cause of death? þ page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes, 2 25. Was case referred to dica funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 2 Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practice 1 to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

30. Name

NOV 1

5 201

7505 () 32. Registrats Signature

address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 13 2011 P^{M} November 5:00 Dorothy Hyland Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel Glen Burnie Health & Rehabilitation Birthplace (State or Foreign Country) If Under 1 If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year, Hours 1 🗆 M 2 💢 F Director 217-16-4157 Nov. 20, 1922 Maryland 88 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 🗆 Yes 2 😾 No Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 21060 United States 1725 Marley Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status ral", or iten Examiner Black, White, etc. 1 Never Married 2 Married Yes 2 X No Yes, Give 21215-0036 1 Yes 2 No Specify White "natural" 3 ☐√Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Sales Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Beulah Maxine Hyland Milton Franklin Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 1725 Marley Avenue, Glen Burnie, Maryland 21060 Department of Health Important: If item 27 any injury or other tr Stuart Kelly / Brother altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/15/2011 | Baltimore, Maryland Taylor 22. Name and Address of Facility Cremation Society of Maryland Signature of Funeral Service Licensee Alyson K 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events lunon or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Pregnant at time of death detached 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, After this certificate has been sideneral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform or Attending Physician: The 2 🗌 No Yes 2 👿 1 Tyes **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier NOU ISTUZOII

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36283 State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov. Physician/ David Eugene Black, Sr. 2011 12:10p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Transitions Healthcare Sykesville Carroll 8. Date of Birth
(Month, Day, Year) If Under 1 Year | If Under 24 Hrs Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 1 X M 2 D F Months Hours Maryland Director |218-34-1200 75 1935 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Carroll 1 Yes 2 No Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 3076 Park Ave. 21102 U.S.A. items "natural", or item ledical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant. If item 27 is marked other than 'ury or other traumatic event, the Me Carroll County Elementary/Seconday (0-12) College (1-4 or 5+) 10 General Maintenance Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Henry Black, Jr. Gladys Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry G. Black - son 3059 Forest St. Box 183, Manchester, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o New Lutheran Cem. Nov. 17,2011 Manchester, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Bull 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death AIZHEIMEN Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 2 🗌 No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy nerformed' death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🖺 completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation s a er death 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of equifier 29c. License number 29d. Date signed (Month, Day, Year) 057722 NOVEMBER 15 2011 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q GREENE TREE ROAD #300 PILESVILLE MO 21208 LEONARD RICHARDSON M.P. 1838 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 7,8 per fh g922 12-8-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 9. 2011 4:40 P Thomas Ray Boone Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Center Towson If Under 8. Date of Birth (Month, Day, 1924 Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last hirthday) **Funeral** Days Months Hours 87 _{Yrs} Director 216-20-9123 1 ፟፟X M 2 □ F 2, Virginia 1925 Nov Usual Residence of Decedent 28a-f show 10d. Inside City Limits ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No Maryland Baltimore Pikesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21208 USA 8909 Reisterstown Road ed other than "natural", or items event, the Medical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 Specify White 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 11 Aggregate n/a Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Boone Lela Burchett other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If Item 27 is any injury or other trau once. 2216 Sykesville Road, Westminster, MD 21157 Essie Jean Knott/Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Falls Road Chapel Cem. 11/14/11 Butler, Maryland vice Lice. Fyneralse Bryan V. 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Bryan 23a. Part 1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ menra disease or condition resulting in death) Medical Due to as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 as the k IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown the be detached 1 ☐ Yes 2 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed? Yes 2 No Il or Attending Physician: The la after death.
Director: After this certificate h 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 X No Other: 1 🗌 Yes 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence ျှ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital c within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature 8503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON 31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Physician/ 10:30 P^M CARMELLO C. BUSCEMI 2011 NOVEMEBER Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death HARFORD Examiner BRIGHTVIEW ASSISTED LIVING BEL AIR 8. Date of Birth
(Month, Day, Year)
MARCH 3,1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. 1 😿 M 2 🗆 F Months Days Hours 90 215-05-0677 MD **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State with the Maryland Director 1 Yes 2 No be notified BEL AIR MD HARFORD 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number USA Funeral 23a 21014 300 EAST RING FACTORY RD permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No Specify: Yes 2 X No Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates Completed 3X Widowed 4 ☐ Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) r than ", Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Importants If item 27 is marked other than any injury or other traumatic event, the Nonce. MANAGER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY PANZERALLA JOSEPH BUSCEMI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BEL AIR, MD 21014 1707 BERDAN CT. GARY J. BUSCEMI-SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE, MD 11/12/11 GARDENS OF FAITH 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELATR 21. Signature of Fune al Service Licensee BR BEL AIR, MD 21014 610 W.MACPHAIL RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ears disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant. 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 4 ☐ Pregnant at time of death g ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Division of Vital Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Anatural 5 Pending 2 No 2 Accident Investigation Director; / Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed Month, Day, Year, Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ NOVEMBER 8 2011 9:06 ALAIN BURK Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 Å M 2 □ F Hours September 14,1974 Months Connecticut 37 040-84-4670 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location hours after death with the Maryland Director 1 ☐ Yes 2 🎽 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral er than "natural", or items 23a the Me tical Examiner must b 13105 Elsdale Court, #205 20851 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces Yes 2 X No þ 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Proposal Coordinator Contracts Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Janet Skirchak David F. Burk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 71 Northwoods Road, N. Granby, Connecticut, 06060 David F. Burk/Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition November 11, 1 Burial 2 Cremation 3 Removal from State Bethesda, Maryland 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Signature of Funeral Service Licensee Rockville, Inc. 300 West Rockville, Maryland 20850 Montgomery Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final moromo 4 months Priysician disease or condition resulting in death) Medical Examiner 3 months Sequentially list conditions any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed inding physician and use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a, Was an To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director, After this certificate has k completed filled in by the funeral director, page 2 sl prior to completion of cause of performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifig 2011 MANISHA BHUTANI, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 10 CENTER DRIVE BETHESDA MD 20892 BHU MANISHA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GRACE CATHERINE BECKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Glen Burnie Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🗷 F Hours Min. 96 214 14 0684 Director MD Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 X No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 1251 Hillside Rd U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify: If Yes Give Specify. 3

Widowed 4 □ Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12Own Home Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Catherine Bishop George A. Schuman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 Nancy W. Cox - daughter 1502 Jupp Rd Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Glen 11/14/11 4 Donation 5 Other (Specify) Haven Mem Pk Glen Burnie, MD 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Funer 1 rvige Licensee 169 Riviera Drive Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ttending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Live Birth 2 Fetal death Month Day Year 5 Other (specify) Pregnant at time of death sbeen signed by the should be detached Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed certificate has been 24b. Were autopsy findings available 24a. Was an page 2 autopsy prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 유 1 Tyes 1 Minpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Dath 28a. Date of injury 28b. Time of 28c. Injury at Certificate: Natural 28d. Describe how injury occurred (Month, Day, Year, injury 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) death (Item 23a) (Type, Print) who completed cause of Da 32. Regist State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27PM Physician/ Nivema Medical Facility Name (if not institution, give street and number, Town, or Location of Deat 4c. County of Death **Examiner** MOY If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs ast birthday) **Funeral** 261-23-5208 Months Director 1**X**] M 2 □ F Yrs 3 1943 India Aug 68 or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at Funeral Director Anne Arundel Crofton MD 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2711 Bains Court 21114 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Examiner Black, White, etc. 9 þ 1 Never Married 2 🔀 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Divorced 4 Divorced Asian the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Gas Station Self- Employed 12th 4yrs t. Page 1 and 2 should be filed with trent of Health and Mental Hygier trant: If item 27 is marked other t jury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mehdi Hassan Bhatti Akbari Begum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ct. Crofton, Maryam Bhatti - Wife 2711 Bains 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Department o Important: If any injury or Memorial Pk. 11/10/11 Randallstown, MD Donation 5 - Other (Specify) Si matur df Funeral Service License 22. Name and Address of Facility 4300 Wabash Av. Inc. Balto., MD 21215 March Funeral Home West, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Combal disease or condition meningitis Medical resulting in death) Due to (or as a consequence of) Examiner Cerebra) Voctor States Examine Due to (or as a consequence of) if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death the 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 After this certificate has Yes 2 No 26. Place of Death (Check only one) the funeral director, 25. Was case referred to medica Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo မ 1 XInpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No 1 Yes within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 3 29b. Signature and title of certifier 29c. License number Date signed (Month, Day, Year) 201 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yama Akbari MD 1000 N WOLFE Street Baltmore

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Year)

State Registrar

DHMH 17 Rev 1/2001

4940 Eastern Avenue, Baltimore, MD, 21224

11-08254 Kelsey Brooks

Physician/ Medical Examiner

> Fune Direct

1- For Stat Registrar 1. Decede

i idada i tha di i iliit ili bidat iliacilbie iliti Filodia VII dopies Vie Fedible' (1) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.
I. Decedent's Name (First, Middle,Last) Kelsey Douglas Brooks Brooks 2. Date of Death Month Day Year November 4, 2011 3. Time of Death 0014 hrs 4b. City, Town, or Location of Death Shady Grove Adventist Hospital 4c. County of Death Montgomery
Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 37 Yrs. 7. Age (In yrs. last birthday) 1 X M 2 F 37 Yrs. 7. Age (In yrs. last birthday) 1 X M 2 F 37 Yrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 1 X M 2 F 37 Yrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 1 X M 2 F 37 Yrs.
Oa. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Rockville 1 Yes 2 No
0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 938 Elmcroft Blvd 20850 U S A A A
1. Marital Status 1. Marital Status 1. Mever Married 2 Married 1. Wildowed 4 Divorced If Yes, Give Year or Dates: 1. Decedent's Education (Specify only highest grade completed) 1. Mas Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Yes 2 No specify: 1. Yes 2 No specify: 1. Yes 2 No specify: 1. Yes 2 No specify: 1. Yes 2 No specify: 1. Specify: Black

	Shady Grov	e Adventi	st Hospital	·		Rockville Montgomery						nery				
	5. Social Security N	Number	6. Sex	7. Age (In yrs.	last birtho	day)	If Under		If Under	24Hrs.	8. Date o	f Birth(N	M/DD/YYYY		hplace (State	or
r	431-61-2		1XM 2F	37		Yrs.	Months	Days	Hours	Min.	80	25	74	Foreig Cou	n untry) <u>I L</u>	,
1	Usual Residence o															
1	10a. State	10b. County		10c. City	, Town or	r Locatio	n								10d. Inside C	ity Limits
į į	MD	ckv	cville							1 Yes	2 XNo					
<u> </u>	10e. Street and Nu		10f. Zip C	ode				10g. (Citizen of Wh	at Cour	itry?					
Director			20850					U.S.A.								
To Be Completed by Funeral Director	11. Marital Status 1 Never Marri	ed 2 XM		Decedent s, specify (14. Race White		merican Indian, Black, c.				
y F	3 Widowed	1 🔲 🦴	Yes 2 X No specify:						Specify:	Bla	ack					
8	15. Decedent's Ed			t's Usual Occupation (Give kind of work done ost of working life, DO NOT use retired)						o. Kind of Bus	siness/Ir	ndustry				
<u>e</u>	Elementary/Seco	-									_	_				
Completed	12th gr	ade		Une	mplo	ye	ď				Un	emp	ployed	İ		
၂ ပိ		17. Father's Name (First, Middle, Last)								- '			en Surname)			
Be	Robert	Robert Brooks								Mattie Moore						
ျ	19a. Informant's Na						ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmcroft Blvd, Rockville, Md 20850									
	Karen Br	ooks-	-Wife		93	38 E	lmcr	oft	: Bl	vd,	Roc	kvi	lle,	Md	20850)
	20a. Method of Disp	_			Place of I		on (Name	of ceme	tery,		Date	20	c. Location -	City or	Town, State	
	1 33	_	3 Removal fr	om State	Elm	,				11/	12/2	011	Titt	1.	Doole	71 17
	4 Donation 5 21. Signature of Fu				I		Jawn 11/12/2011 Little Rock						ROCK,	AK		
	Longe	OC.	Spright	Y		Mar 430	ch E O Wa	Mabas	Wes sh A	ve.	Bal	tim	ore,	Mđ	21215	5
1	23a Part I. Enter th failure, List onl	e disease, or y one cause	complications to at con each line.	enter the	bo Wabash Ave, Baltimore, Md he mode of dying, such as cardiac or respiratory arrest, shock, or heart						rt	Approximate Between Or	nterval			
~	Immediate Cause (I	ovas	ascular Disease							Death						
	or condition resulting in death) Due to (or as a consequence of):															

Physicia /Medic aminچھ

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit

Physiclan/Medical

Completed by

Be

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Medical Certification:

State Registra

4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi

Box 68760,

Division of Vital Records, P.O.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, MD 21215-0036

Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

X UNPENDED

1 Yes 2 No 9 Unknown

AMENDED 23a, 27, per me, g922 12-21-11 sm IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth past 12 months?

Pregnant at time of death 5 9 Unknown

Due to (or as a consequence of):

Due to (or as a consequence of):

3 Ectopic pregnancy Fetal death Other (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28b. Time of Injury

25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA 1 Yes

28a, Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be

determined

(Specify)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

31. Date filed (Month, Day, Year)
NNV 1 5 201

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 ✔ Unknown

death?

28f. Location (Street and Number or Rural Route Number, City

November 4, 2011

29d. Date signed (Month, Day, Year)

1 Yes

Day

24b. Were autopsy findings available

prior to completion of cause of

Year

2 No

Month

24a. Was an

Other Nursing Home 5 Residence 6 Other

autopsy

performed?

28d. Describe how injury occurred

✓ Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:00 р м November [™]f3, 20㎡1 William Ronald Chesbro Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Burtonsville Sanctuary @ Holy Cross If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (in vrs. last birthday) Funeral Days New York 1**X** M 2 □ F Months Hours 6, Director Oct 1928 110-20-3396 Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Funeral Director 1 Yes 2X No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3128 Gracefield Road HS612 20904 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Was Decedent Ever In U.S. Armed Forces? 1☑ Yes 2 □ No If Yes, Give Year or Dates. 1948–50 the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. ŏ δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+)
5+ Elementary/Seconday (0-12) Professor of Microbiology Education/Research of Health and Mental Hygi item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ronald Chesbro Mary McGaughey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau 3128 Gracefield Rd. HS612 Silver Spring, MD 20904 Ruth Z. Chesbro/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2X Cremation 3 🗀 Removal from State Final Journey Crematory 11/15/11 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Name and Address of Facility Ting home Cremation Service P.O. Box 784 MD 21029 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ espira disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျှ 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00069 χ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

2835 Smith Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	State Registrar	,	Cer	tificate of D	Death		Reg. No. 2		30292
	Di		1. Decedent's Name (First, Middle, Last,)				Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia Medic		Bonnie Inman Col	lins						2, 20L	1 3:10 PM
	Examin		4a. Facility Name (if not institution, give s			4b. City, Town, or	Location of Death		4c. County	of Death	
e e e	·		Gilchrist Center				Towson			Ltimore	
	Funeral Director		5. Social Security Number 213-60-0120 Usual Residence of Decedent	7. Age (In yrs. lat M 2 F 59		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Mar 19	y, Year) 1952	Country)	ce (State or Foreign rland
	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	5	10a. State 10b. County	10c. City	, Town or Loc	cation			-	10d	. Inside City Limits
	laryla 3a-f s ified	Funeral Director	MD Baltim	ore M	onkton						1 Yes 2 No
	or 28	늅	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	?
	with 1	eral	717 Monkton Road	1		2111	1		Unit	ed Sta	tes
	eath tems er mu	'n.		12. Was Decedent Ever in U.S.	. 13. V	Vas Decedent of Hi	ispanic Origin? (Spe	cify Yes or No-		ce - American	
9	or if	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No		Yes, specify Cuba	n, Mexican, Puerto	Mican, etc.)		ck, White, etc.	
200	ural" ural"	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		Li Yes 27CFINO	<i>эреспу.</i>		Specify	W1	hite
2-("nat"	Completed	15. Decedent's Ed (Specify only highest grad		(Give I		ation Iuring most of worki	ing	16b. Kind of B	lusiness/Indus	stry
2	thin 7	Som	Elementary/Secondary (0-12)	College (1-4 or 5+)		O NOT use retired)			Heal	th Car	e Facility
N D	ed wi Hygie other ent, tl	Be (17. Father's Name (First, Middle, Last)		Car	egiver	18. Mother's Name	e (First Middle.			C rucilloj
Maryland 21215-0036	be filk ental ked c	욘	Byron Wallace In	man					lschlage		
<u> </u>	ould nd Me mar mati		19a. Informant's Name/Relationship (Type		19h Mailin	a Address (Street :	and Number or Rura	al Route Numbe	r. City or Town. S	State, Zip Coc	de)
Š	12 sh lith ar 27 is r trau		Kathy Maxwell /S				Drive C				
ē,	1 and f Hea item othe		20a. Method of Disposition		ace of Dispo	sition (Name of		Date	20c. Location		n, State
Ë	Page nent o int: If		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	nemoval nom state		natory or other place e Cremato		Nov 15, 2011	Belts	sville,	Maryland
Baltimore,	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service License	Pe 1014	43 22	. Name and Addres	ss of Facility n and Fune	ral Alt	ernative		
10			anda Sue	Rilling		8717 Gre	en Pasture	s Drive	Towson	Marylar	nd 21286
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only on	lications that caused the death e cause on each line.	. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory ar	rest,	. In	pproximate nterval Between
- z.	Ph, sician/		Immediate Cause (Final disease or condition	Metast	ale.	lerez	st can	Car.			Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	1,50,000		The First Co.			T
	<u> </u>	7	Sequentially list conditions,	b. —						_	
	sit sit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence ot):						
	executed an and rial-transi	Exa	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):						
	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Medical Examiner		۵.							
8/60	tificate be ng physicia as the bu	ledi		u							
9	certif nding use a	*	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy] =			23d. Da	ate of delivery	
ROX	leath e atte id for	Physician,	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal		Other (specify)	су		M	onth Da	ay Year
	the c by the tache	hys	9 Unknown	9 Unknown							
J.	s that gned se de	by	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	1			cause of death?
gp	equire sen si ould	ted						1 🗆			bly 4 Wonknown
Vital Records,	aw re as be	Completed						24a. Was auto	psy	prior to comp	y findings available pletion of cause of
Ž Ž	The cate h	Con							2 No	death? 1 Yes 2	□ No
ta	cian: ertific	Be	25. Was case referred to medical examiner?	lospital:			ace of Death (Chec	k only one)			
>	Physi this c al dir	2	1 Yes 2 AH5	1 ☐ Inpatient 2 ☐ I	ER/Outpatier 28b. Time of		4 L Nursing Ho		-		Hospice.
n ot	ding l h. After funei	Certificate:	1 Natural 5 Pending	(Month, Day, Year)	injury	28c. Injun work M 1 🗆	y at (? Yes 2 \sum No	28a. Describe	now injury occur	rea	,
SIO	Atten deat ctor: y the	rtiti	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor	me, farm, stre		103 2 110	28f. Location (Street and Numb	ber or Rural R	oute Number,
DIVISION	al or / s after il Dire ed in b	Ce	4 Homicide determined	building, etc. (Specify)				City or To	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for completely filled in by the funeral director, page 2 should be detached for	Medical	(Check 2 Medical Examin	ician: To the best of my knowle ner: On the basis of examination e Practitioner: To the best of m	and/or invest	igation, in my opinio	on, death occurred a	t the time, date :	and place, and di	ue to the cause	e(s) and manner stated.
	To the Congression	_	29b. Signature and title of certifier			29c. License			29d. Date signe	ed (Month, Da	y, Year)
	1.4.		Brook	MD		D7	1040		[[]2	-111	·····
	'DON'		30. Name and address person who co	ompleted cause of death (Item	23a) (Type, F						
			ARATHI CUMA 31. Date filed (Month, Day, Year)	18 6701 Ne	thank	s St S	WITE 410°	= BA	TIMORY	BM	Q.
	Stal Registra		NOV 1 5 2011	32. Registrar's Signatu	bark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25, per me, e922 12-8-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:52A M Month Year Physician/ CLARK Lounber LEE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Ballimore OWSDIN St. Joseph Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country) 1 XM 2 □ F Director 66 10d. Inside City Limits show 10c. City, Town or Location 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore 1 XYes 2 ☐ No MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral Shachside Koad 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 13 ack If Yes Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

ASSUMDER the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) uepartment of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event; the Menoe. College (1-4 or 5+) Elementary/Secondary (0-12) General Motors 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Clark မ Augburn William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Battimore, MD 21234 wife Avenue Catherlem 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/18/201 Timpnium, MD Valle Dulaney C. Greene Funera Sriks augn 21, Signature of Funeral Service Licensee 2. Name and A dress of Facility Randalistown MD 21133 Vausa Road disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. 23a. Part 1. Enter the shock, of heart Interval Between Onset and Death Immediate Cause (Final Physician/ Y-SOTS/A DISCHSE COROMARY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): as the burial-transit ABUSE the Hospital or Attending Physician; The law requires that the death certificate be executed DRUG CATION APPROVED BY that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ase fyes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L Fetal ueu
Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? for 2 No 1 Yes 2 9 Unknown this certificate has been signed by the arral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ER/Outpatient _3 DOA ျ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certificate: 1 Natural within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suiciae4 ☐ Homicide determined ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c D29301 11-14-11 MD LUTHERVILLE who completed cause of death (Item 23a) (Type, Print) 12 30. Name and address of person BRIGHTFIEDD BIRLGHTWOOD MD 21093 KATE MULY MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tony Curry 10,2011 5:10A November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Morningside House of Friendship Anne Arundel Hanover Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Director 234- 20-1 ▼ M 2 □ F 8117 March 18,1922 West Virginia 89 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location Director Md. Anne Arundel 1 🗌 Yes 2 🗶 No Hanover ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7540 Old Telegraph Road <u> 21076</u> ural", or items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ō 1 Never Married 2 Married Completed by Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural" White 3 😾 Widowed 4 🗆 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 77 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Foreman Events Company 12thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 .. Page 1 and 2 should be trent of Health and Ment tant: If item 27 is marked jury or other traumatic e David Curry Antha Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Curry Son 307 Wisteria Court BelAir, Md 21015 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11-12-2011 Glen Burnie, Md. 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licenses ~ 9705 Belair Road Nottinmgham, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final Ph sician/ C41 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or it that initiated events nding physician and use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the the Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 ANO 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 400 은 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation M filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Medical 🖴 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

to bat

1/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Raymond corpenter Physician/ Month November 7:23A 1105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5309 Tolson Road Temple Hills Prince George If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Director 036-20-8848 1 🕱 M 2 🗆 F North Carolina 06/21/1931 80 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Temple Hills MD Prince George ō 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g, Citizen of What Country? Funeral 5309 Tolson Road 20748 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify "natural", Specify: Completed 3 Divorced Black Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Moving & Storage 6 Truck Driver Be permit. Page 1 and 2 should be flied Department of Health and Mental Hy Important: If item 27 is marked ottany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Horton Rixie Carpenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deatrus Carpenter / Wife 5309 Tolson Road, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 11/14/2011 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) . Signature & Funeral Servi Lice Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the dis shock, or heart failur ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Umphoma Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier/ 29c. License number **D0057465** MSRyapathem.D 29d. Date signed (Month, Day, Year) 11/10/11

Registrar

32. Registraris Signature

5 203

BAlhmore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 1 5 2011

N. S. Rajapakse, M.D. 2835 Smion

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death A Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7333 Berkshire Road Dundalk Baltimore City Funeral 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min (Month, Day, Year) 11-19-1941 Country) Director 214-40-1771 69 Usual Residence of Decedent 23a or 28a-f show 10b. County 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1X☐ Yes 2 ☐ No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7333 Berkshire Road USA 21224 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Olan Mills Photography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Joseph Mathiot Lillian (Frey) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Craft Daughter <u>7333 Berkshire Road Dundalk,</u> MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🌠 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) <u>Meadowridge Mem Pk</u> 11-17-2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home, PA 7110 Sollers Point Road Dundalk, MD M01176 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached for 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an performed? Yes 2 No 2 🗌 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital မ 1 Yes 2 No After this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year) 10/11 454 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUTTE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Jerome Cusimano

11-08082 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-08082 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ink Unk	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. O 1 1 0 C 2 C
, myoronam	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Name (First, Middle,Last)
Medical Examiner	Jerome Cusimano October 28, 2011 October
	Johns Hopkins Bayview Medical Center Baltimore
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Hours Min Let 1.7. 10.5 / Foreign Months Days Min Let 1.7. 10.5 / Fore
Director	213-68-4714 1X M 2 F 57 Yrs. March 17,1934 Country) Hary Land
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Md Baltimore 1 X Yes 2 No
the Maryland to 28a-fsh iffed at onco	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
eath with the Maryland items 23s or 28s-f sho ust be notified at once ineral Director	5404 Belair Road
r death with or items 22 must be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
fer d	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year of Dates: 1 Yes 2 No specify: Specify: White
5 72 hours al Exami leted t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)
136 hin 72 e. than " edical	Elementary/Secondary (0-12) College (1-4 or 5+) 12+h Salesperson Retail
21215-0036 Muld be filed within 7 Mental Hygiene marked other than c event, the Medica	17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname)
121 d be fill lental I. sarked event, j	Joseph Cusimano Doris (Unknown)
MD 21 d 2 should lith and Me lith and Me n 27 is ma numatic co	19a. Informant's Name/Relationship (Type, Print) JoAnn Lipsitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5340 Wright Avenue Balto. Md. 21205
	20a. Method of Disposition
Baltimore, oemit. Pages I ar Department of He Department of He Important: If ite injury or other tr	4 Donation 5 Other Specify: Lakeview Mem. 11-15-2011 Sykesville, Md.
Salti ermit. Pepartri mports sjury o	21. Dignature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc.
Physician	9705 Belair Road Nottingham, Md. 21236 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a Coronary Artery Thromboses Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):
6	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
nsit Examiner	cause. Enter Underlying Cause (Lineasse or injury that initiated expents resulting in death). Last Due to (or as a consequence of):
nd ransit	events resulting in death) Last Due to (or as a consequence or): d.
Box 68760, death certificate be executed the attending physician and if for use as the burial - transi ysician/Medical E.	☑ AMENDED 23a,27,per me,g921 11-16-11 sm
68760 certificate be nding physise as the bu	IF FEMALE: 23b. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year
ox 6876(eath certificate attending phy for use as the trician/Me	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
D. Box 6876 i the death certificate by the attending phy ached for use as the Physician/M	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ires that to signed by the detact	1 Yes 2 No 3 Probably 4 ✔ Unknown
of Vital Records, of Physician: The law require. ther this certificate has been signeral director, page 2 should be not To Be Completed.	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
teco	performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Recion: The certificate ector, page	25. Was case referred to medical 26.Place of Death (Check only one)
Physic er this real dir.	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other. 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
on o	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No
Division tal or Attendir rs after death. al Director: A led in by the fu	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division o ospital or Attending hours after death. nortal Director: Afte y filled in by the fune Certification:	4 Homicide determined (Specify)
8 2 2 2 9 9 9	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within 2 To the complet	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	Caral Hallan O.C.M.E. October 28, 2011
	30. Name and address of person who completed cause of death (Item 23a)
State	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 31. Registrar's Signature
Registrar	NOV 1 5 2011 Lewer B. Garles

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jovember anie 0037 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death, **Examiner** 4c. County of Death Hophins Johns Battimor 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Months Days **Director** 214-36-4853 1 □ M 2XXF Dec. 6, 1939 71 Yrs. Washington, D.C Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2XXNo Maryland Howard Elkridge 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 6765 Pirch Way 21075 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates 3₩Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Hostess Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Herbiemont Holtzman Virginia Wheeler Steinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is I Laurene Lynn (Daughter) 3097 Crown Circle, Manchester, MD 21102 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it cemetery, crematory or other place)
Faiths Crematory
& Chapel 1 Durial XX Cremation 3 Removal from State 11/15/2011 injury 4 Donation 5 Sther (Specify) Manchester, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr., Manchester, MD 21102 23 (Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ 14 18 itain c disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Day 5 Other (specify) Month Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 \Box Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 🗡 Inpatient 2 🗆 ER/Outpatient 3 🗆 4 Nursing Home 5 Residence 6 Other (Specify DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Wolfe St. Baltimore, MD, 21287 600 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar
DHMH 17 Rev 06-2011

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security Number 218-32-3702	6. Sex 1		7. Age (In yrs. 7)			Days Hou		8. Date of Bir (Month, Da Oct. 18	tn ay, Year) I	935	Birthplac Country) Mary	ce (State or Foreign
show	or	Usual Residence of Decedent 10a. State 10b. Cour	nty		10c. Ci	ty, Town or Lo	cation	_					10d	. Inside City Limits
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or dear	by Fu	11. Marital Status1 ☐ Never Married 2 X N	1	Vas Dece Armed For □ Yes		S. 13. V	Vas Deceder f Yes, specif	nt of Hispanio Cuban, Me	c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ai Black, W		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed b	3 Widowed 4 Divord	ا ا	f Yes, Give ear or Da	e	1	I ☐ Yes 2	X No Spe	ecify:			Specify:	Whit	:e
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age 1 ent of nt: If it y or o		1 🔀 Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe		oval from	State Por	olar Gr	natory or oth OVE	er place)		Date 17, 011		hoenix		
permit. P Departm Importai any injur		21. Signature of Funeral Service			Cei	metery 22	. Name and	Address of F	acility					
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Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a		DNGES		tEAR"	TAI	LURE				l "	niset and Death
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cian: ertific ector,	Be	25. Was case referred to medic examiner?	al Hospi	tal:					Death (Chec					
Physi this cral din	<u>۲</u>	1 Yes 2 No 27. Manner of Death		1 🗆	Inpatient 2	ER/Outpatier 28b. Time of		Other: 4		ome 5 Resi			ecify)	
nding tth. : After e fune	cate	1 Natural 5 ☐ Per			h, Day, Year)	injury	M Z	work?		26d, Describe	now inju	y occurred		
r Atter	Certificate:	3 🔲 Suicide 6 🗆 Cou	ld not be		of Injury - At h		eet, factory,	office	1000	28f. Location (Rural Ro	oute Number,
oital or urs aft ral Dir		~												
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medica	I Examiner: C	n the basi	is of examination	on and/or invest	tigation, in m	y opinion, dea	ath occurred a	nd due to the ca t the time, date ce, and due to the	and place	e, and due to t	he cause	e(s) and manner stated.
To the within To the Comp	_	29b. Signature and title of certi	red /	2 1			29c.	icense numb	ber		29d. Da	ite signed (Mo	onth. Da	v. Year)
		Syld	All	ba	- MD		D	7213	9		Not	rem bez	14	2011
ე √		30. Name and badress of persons by ED A13BAS	on who comple	eted caus	e of death (Iter	n 23a) (Type, F	Print) ST	SuiT	TE 410	5 BM	TIME	DRE M	0 2	21204.
Stat	е	31. Date filed (Month, Day, Yea)	32.	gistrer's Signa	ituro -	ake							
Registra	ır	NUVI	5 2011	[A	wa.	1. A.	THE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Rosalie November 2011 Mary Dzbinski 3:30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Autumn Assisted Living Harford Fallston If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Maryland 1 🗆 M 2 🕱 F Months Days Hours 90 M0727/1921 Yrs Director 215-12-9150 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Funeral Director filed within 72 hours after death with the Maryland 1 Yes XX No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 602 Squire Lane Unit D Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White 3 ▼ Widowed 4 □ Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working d 2 should be filed within 72 alth and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Admin. Assistant Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence Frank Vavrina Healy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 602 Squire Lane Unit D, Bel Air, MD David Dzbinski 21014 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Holy Redeemer Cem Baltimore, MD 11/11/11 Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FUneral Home, Bel Air 610 W. MacPhail Re 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ CARDIOJASCU a. Atheressclerone years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence on) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day 5 Other (specify) been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒️No 24a. Was an s certificate has blirector, page 2 s performed? Yes 2 A No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗎 Residence 6 😿 Other (Specify) Hospital: 1 🗌 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA LIVING within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5522 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue 2101 2. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NDA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P.SOV OWN Medical 4a Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Year If Under 8 Date of Birth (Month, Day, July 1, **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Hours Min West Virginia Director 234-66-3808 1942 69 Usual Residence of Decedent -f show 10a. State 10b. County 10c. City. Town or Location items 23a or 28a-f sho er must be notified at 10d. Inside City Limits Director 1 Yes 2X No VA Loudoun Leesburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19355 Cypress Ridge Terrace 20176 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status "natural", or iten edical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Communication Public Relations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transponse. ပ္ Robert Littleton Downey Wanda Swann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6804~Weaver~Ave.~McLean,~VA~22101Raymond Patrick Freson/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 11/16/11 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Moutec Value Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number RES - 000 November 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neuin Mikatz , M.O.

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

5 2011

32. Registr

1. De	Registrar			<u>Ce</u>	rtificate of	Death		2. Date of Death Month	5Day	2011	3 6 3 0 3. Time of Death	
niner 4a. Fa	ARA GLADYS FINK cility Name (if not institution		number)		4b. City, Town,			INO V LADER	4c. Coun	ty of Death		
5. Soc or 21	OCUST LODGE ial Security Number 4.24.9963	6. Sex		. last birthday) Yrs.	If Under 1 Yea	nder 1 Year If Under 24 Hrs. 8. Date of Birth					blace (State or Forei try) MD	
Funeral Director 10e. S 11. M.		ARUNDEL		City, Town or Lo	ocation			10d. Inside City Limit				
10e. S	Street and Number				10f. Zip Code 21122			10	10g. Citizen of What Country? USA			
a 1[arital Status ☐ Never Married 2 ☐ Mar X Widowed 4 ☐ Divorced	ried Armed			Was Decedent of If Yes, specify Cu	ban, Mexican	, Puerto R			ace - Americ ack, White, fy: WHI	etc.	
O	15. Decedent's Education (Specify only highest grade completed) (Gir Elementary/Secondary (0-12) College (1-4 or 5+) (iife.					e during most	t of working	g	16b. Kind of Business/Industry OWN HOME			
P AL	ther's Name (First, Middle, L				ne)	_						
	nformant's Name/Relations ROLE PATCH		DAUGHTER		ing Address (Stree HARBOR RD.				City or Town,	State, Zip (Code)	
1	Method of Disposition XXBurial 2 Cremation		om State	cemetery, cre	osition (Name of matory or other p				Oc. Location			
	□ Donation 5 □ Other (S gnarife of Funeral Service L K GREÇÖRY FIN	Certse	M01148	É	RAL CEMETE INKTEUNERA 26 CRAIN F	ressinome ilit			-	I MORE,	<u> </u>	
Sequence of the second of the sequence of the	Interval Between Conset (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Interval Between Conset and Death Cauch or Vasculus Disease or Conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Interval Between Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Vasculus Disease or Conset and Death Cauch or Cauch or Vasculus Disease or Conset and Death Cauch or Cau											
sicia	MALE: Vas decedent pregnant n the past 12 months? Yes 2 XX No Unknown	1 □ Li 4 □ P	outcome of preg ve Birth 2 Fe regnant at time on nknown	Ectopic pregna Other (specify)	ncy			23d. Date of delivery Month Day Year				
Completed by Ph	. Other significant condition	ons contributing t	o death but not r	esulting in the	underlying cause	given in Part I	I. 		s 2 X No	3 ☐ Pro	ne cause of death? bably 4 \(\sum \) Unknow psy findings availab impletion of cause of 2 \(\sum \) No	
ф 25. W ех	as case referred to medical aminer? Yes 2 No	Hospital:	☐ Inpatient 2	FB/Outpatie		Place of Deat		o <i>nly</i> one) ne 5 🗌 Resider			D LIVING	
titicate: 27. M. 1 2 3	Anner of Death Natural 5 Pendir Accident Investig Suicide 6 Could	28a. Da (M) gation not be	ate of injury lonth, Day, Year)	28b. Time of injury	of 28c. Inj	ury at ork? □ Yes 2 □	No 28	8d. Describe hov	v injury occu	rred		
29a.	Homicide determ	p Physician: To th	ilding, etc. (Spec	wledge, death	occurred at the ti	me, date and	place, and	City or Town,	State) se(s) and ma	nner as stat	red.	
ě	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year)											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36303 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 9, 2019 7:00 p м Ronald Wesley Griffith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 7710 Woodmont Avenue #1005 Bethesda Date u. (Month, Day . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min **Director** 216-58-8496 58 1952 Pennsylvania Dec Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 ☐ Yes 2X No Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral with USA 20814 7710 Woodmont Avenue #1005 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Salesman and Mental Hygie is marked other permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, til onee. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ward Willson Griffith, III Rene Honey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7710 Woodmont Ave. Apt 1005 Bethesda, MD 20814 Constance W. Griffith/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Final Journey Crematory 11/14/11 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 MD 21029 Beverly L. Heckrotte, P.A. Clarksville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Amyotrophic Lateral Sclerosis disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 this certificate 1 Yes 2 No Yes 2X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 1 \(\text{Nesidence} \) 6 \(\text{Other} \) Other (Specify) 2 XNo ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 X Natural 5 \square Pending 1 Yes 2 No Accident 24 hours after death Funeral Director: the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 🗌

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Registrar

29b. Signature and title of certifier

Coleman, M.D. 1355 Piccard Drive Rockville, MD 20855 NOV 1 5 2011 32. Registrar's Signature

30. Name and address of person who completed cause of deat! (Item 23a) (Type, Print)

29c. License number

D37142

29d. Date signed (Month, Day, Year, November 10, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2-40P M MARY E. GLADDEN Nov. 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caton Manor Nursing Home Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 20, 1942 South Carolina Davs Hours Director 213-36-5709 1 □ M 2**X**□ F 69 Yrs Usual Residence of Decedent 3a or 28a-f show be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2521 Serlerno Place 21225 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceden _____ Armed Forces? 1 ☐ Yes 2 🔀 No Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: African 1 ☐ Yes 2 💢 No Specify: 3 XWidowed 4 Divorced Completed Amorican 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Poultry Factory Worker Be 17. Father's Name (First, Middle, Last) Department of Health and Mental h Important: If frem 27 is marked any injury or other 18. Mother's Name (First, Middle, Maiden Surname) Edward Jones (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Gladden/son 2603 Park Heights Terrace Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/16/11 Woodbine, MD Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 He WE MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall uy. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CEREBROVASCULAR ACCIDENT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPERTENSEN Records, DIABETES 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown PNEU MONIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10062634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HICKERY 210GE RD COLUMBIA MD 21.44 MATEEN AWAN 10796 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State NOV 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kathryn Groot November 2011 11:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dove House Hospice Carrol1 Westminster 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. Pennsylvania Director 182-24-3482 80 T931 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PA Adams Littlestown 1 ☐ Yes 2X No ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Wheaton 17340 United States Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1 Never Married 2 Married Armed Force Black, White, etc "natural", or ģ 1 Yes 2 If Yes, Give 2 No Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Director US State Department and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Arthur Groot Delia McKeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Sheedy / Niece 917 Francis Scott Key Hwy., Keymar, MD 21757 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/11/11 Baltimore, Maryland Signature of Funeral Service Licensee $Alyson\ K$ 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transin Cause (Disease of that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Year Day Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Tyes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes ပ္ 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA After this completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury 1 Yes death Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check *Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the the only one within To the 29b. Signature and title of certifie 29c. License number ျ 29d. Date signed (Month Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nancy Alma Grisham 2011 November 6:36 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 218-48-3226 Director 1 □ M 2**X** F 63 May 19, 1948 Maryland 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 ☐ Yes 2 ☑ No Harford Abingdon Maryland ō 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 3009 Scotch Court 21009 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify "natural", Specify: White Completed 3 Divorced 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Cashier / Patient Rep Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked cary injury or other traumment once. 2 Estile Thurman Wilson Rissie Christine Ramey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Wilson, Brother 3009 Scotch Court Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 11/14/11 4 Donation 5 Other (Specify) Baltimore, Maryland Metro Crematory Inc. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final set and Death Ph sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy perform death? s after death.

Director: After this certificate! Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 NO Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) Howsic 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti 29d. Date signed (Month, Day, Year) MD 71040 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ARATHI

31. Date filed (Month. Day.

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NCHARLES

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. 20e1r1 Frank T. Gresdow Jr. 12:35a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death HArford 800 Schucks Road Belair Social Security Number Funeral . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Feb. 5 212-28-2345 1 🗷 M 2 🗆 F Months Hours Min Director 79 1832 MD Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho, any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Harford MD Belair 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21015 800 Schucks Road USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
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✓ Yes 2 □ No þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes. Give Completed White 3 🛮 Widowed 4 🗆 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver New Penn Company 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Florence M. Baker Frank Gresdow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
800 Schucks Road Belair MD 21015 Debby Trent /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 11/16/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 300 Mace Ave. 22. Name and Address of Facility Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
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 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month detached 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughters Hospital 2 **I**No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier ddress of person who completed cause of death (Item 23a) (Typs, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2011 36308

		1- For State Registrar	Ce	ertificate o	f Death		F	Reg. No.	1 3030		
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					4b. City, Town, o	r Location of C	Death	4c. County of Deat	h		
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8760, tificate be ng physic as the bur	n/M	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pred 1 Live birth		tal death 3	Ectopic pr	egnancy	23d. Date of deliver Month	y Day Year		
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Box 687 he death certification of the attending of the death of the attending of the death of th	Physician	1 Yes 2 No 9 V Unknown	9 Unknown								
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i of Vital Records, P.O. B ing Physician: The law requires that the d After this certificate has been signed by the timeral director, page 2 should be detached		27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of I	njury 28c. Inju	ury at Work?	28d. Describe	how injury occurred			
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horm	0	 Name and address of person who Patricia Aronica-Pollak MI 			ann W. Balti	more Street	et, Baltimore, M	ID 21223			
	tate		32. Registra 's Signa	7	OU VV. Daili		A, Daillinoie, IV	ID & 1240			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 11:31 P M 2011 Hubbard November Doris Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13220 Midway Ave. Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday, **Funeral Director** 217-36-6797 1 M 2 X F 73 Yrs 03/24/1938 Washington DC Usual Residence of Deced 28a-f show 10d. Inside City Limits 10c. City, Town or Location aţ 10a. State Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No MD Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20851 United States 13220 Midway Ave death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o မ Regina Wendling John Bass 19 Ringrant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginia A. Laffer / Daughter 13220 Midway Ave., Rockville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò Department of Important: If any injury or Chesapeake Crematory | 11/10/2011 Beltsville, MD 21. Signature of Funeral Service Li 1101539 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Lue to for as a consequence of it any, leading to immedia cause. Enter Underlying use as the burial-trans Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical ul or Attending Physician: The law requires that the death certificate beafter death.
Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the ail 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2v No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Accident 1X Natural 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and t certifi 00057305 9 erson who completed cause of death (Item 23a) (Type, Print) Name and address of JANSSEN, 7 GRANITE PLACE #14, GAITHERSBURG, MD 20878 **JEREMY** M.D.

State

31. Date filed *(Month, Day, Year)* **NOV 1 5 2011**

32. Registrar s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 ay 201 Year 9:40p NO Th Physician/ Peyton W. Harris Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale Franklin Woods Nursing If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 8. Date of Birth (Month, Day, Year Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 230-01-5778 Director 1 □XM 2 □ F 94 Aug. 19, 1917 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director Essex Baltimore MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21221 19 Clipper Road USA be filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", White Completed Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Wet Sander Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Katherine Shepherd William H. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7310 Rush Road Baltimore MD 21206 . Page 1 and 2 sl ment of Health a tant: If item 27 i Stephen Harris /son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl 1 X Burial 2 Cremation 3 Removal from State Holly Hill Cemetery11/14/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Balto. MD 300 MAce Ave. Funeral Home of Essex Connelly 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to or a a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Line Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death Other (specify) signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 No 3 Probably 4 Munknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 the Hospital or Attending Physician: The thin 24 hours after death.

• the Funeral Director: After this certificate himpletely filled in by the funeral director, page Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature dress of person who completed cause of death (Item 23a) (Type, Print) WD31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

NOV 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 12:05 PM 2011 Arthur R. Heiser November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Dundalk 3701 North Point Road Lot 1 Year If Under 24 Hrs.
Davs Hours Min. . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months 180-22-1111 1 🛛 M 2 🗆 F **Director** 81 1930 Pennsylvania Oct 8. Usual Residence of Deced 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County notified at Director 1 🗌 Yes 2 🎇 No Baltimore Dunda1k Maryland 10f. Zip Code 10a. Citizen of What Country? ō 10e. Street and Number must be Funeral items 23a 21222 USA 3701 North Point Road Lot 58 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1948 þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 1973 Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Army Communications 12 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Laura Hawley Anson Parson Heiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 3701 North Point Road Lot 58 Dundalk, MD 21222 Maria Worthen, Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b, Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or once. Metro Crematory Inc. 11/14/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one pall line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown bonic Kidney desose 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 10, 2011 Physician/ 7:30 P M Josephine Joyce Harrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Columbia 7070 Cradle Rock Way #220 If Under 1 Year If Under 2 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Director 107-48-3329 86 Yrs June 19, 1925 (Unknown) "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director Columbia 1 Tes 2 X No Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21045 7070 Cradlerock Way 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates . Page 1 and 2 should be filled within 72 hours trnent of Health and Mental Hygiene. tant: If item 27 is marked other than "natur iury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service 12 Food Service Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unknown) Martina Greenland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7070 Cradlerock Way #220, Columbia, MD 21045 Olivia Gross / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Uniformed Sers. Univ. 11/13/2011 Bethesda, MD 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD The north in the see MC0382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Opset and Death Immediate Cause (Final home discarc Ph_sician/ 9095 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has Yes 2 No ospital or Attending Physician: The hours after death.

neral Director: After this certificate by filled in by the funeral director, pa 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) H-3112 C 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accounted at it. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signatu

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year,

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32. Registrar's Signatur

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 State of Maryland / Department of Health and Mental Hygiene Reg. No. Reg. No. State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 Day TRESIA HARRIS 2011 12: 37a M Nov. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** (Month, Day, Year) 214-72-9161 Days **Director** 1 M 2 F 52 Yrs Mar.5, 1959 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County death with the Maryland aţ 10a. State 10c. City, Town or Location Director must be notified 1 X Yes 2 No MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a Funeral 3110 Cliftmont Avenue 21213 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ò 1 Never Married 2x Married Yes 2 X No Yes, Give and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Disabled yrs. Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William O. Bennett Anna Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christopher Davis - Son 3110 Cliftmont Ave. Balto., MD Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/16/2011 Baltimore, Md 21. Signitule of Funeral Service Licenses 22. Name and Address of Facility 4300 Wabash Av. March Funeral Home West Balto. MD 21215 23a. Par 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Anoxic Dral disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** arrest ardiac Sequentially list conditions Examine in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi arnonyonato and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 y 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? Yes 2 XN 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27, Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury 5 Pending M Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 10 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Apron CHANUES M 6201 N. 25 TOWSON MY unus 31. Date filed (Month, Day, Year) 32. Fighter's Signature State NOV 1

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 10, 2011 4:48 P M Fred Charles Ikle Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery 7010 Glenbrook Road Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 108-26-9020 87 **Director** 1 🕱 M 2 □ F August 21, 1924 Switzerland Usual Residence of Decede 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No Maryland Maryland Bethesda Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7010 Glenbrook Road United States 20814 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Examiner 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Federal Government 5+ Political Scientist Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) should be file and Mental I ပ Maria Hedwig Huber Friedrich Arnold Ikle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7010 Glenbrook Road, Bethesda, Maryland 20814 1 and 2 s of Health item 27 Ikle/Wife Doris Margret 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of November 14, cemetery, crematory or other place) Department of Important; If it any injury or o 1 Burial 2 Termation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2011 rematorium, Inc. Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service 22. Name and Address of Facility Bethesda-Cherylchase08 pc. 7557 Wisconsin Avenue M01498 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Intracranial Hemorrhage due to Fall Medical m Due to (or as a consequence of) Examiner Dementia, Senile Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury Overto for an a consequence of 12 Atrial Fibrillation and that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 the attending physician Physician/Medical Chronic Anticoagulation or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Haknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page, certificate Yes 2 🛭 No 1 ☐ Yes 2 ☐ No rector, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 X Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) ည 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident 1 Yes 2 X No November 1,2011 6:25 A™ Fell getting out of bed Investigation the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10718 Potomac Tennis Lane Potomac, Maryland 20854 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Arden Courts of Potomac Hospital Medical 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medica-Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifing yerse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only 29b. Sigi 29c. License number 29d. Date signed (Month. Dav. Year) November 11, 2011 MD0052247 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 181 7625 Wisconsin Avenue, #101, Bethesda, Maryland 20814

DHMH 17 Rev 06-2011

State Registrar Collin Cullen, MD
31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death Physician/ 2011 Tozzi 5:00 AM Dolores November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** September 7,1946 Director 218-48-3953 Maryland 1 🗆 M 2 🔀 F 65 Usual Residence of Decedent 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 28a-f 1 Yes 2 No Baltimore Dundalk Maryland ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21222 6801 Brentwood Avenue . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc or þ 1 Never Married 2 X Married ould be filed within 72 hours after of Mental Hygiene.

marked other than "natural", or Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Operating Engineers 12 years Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) and Mental I Esther M. Olszewski Stanley A. Dylewski 19a. Informant's Name/Relationship (Type, Print) Lyge 1 and 2 sincepartment of Health an Important: If item 27 is n any injury or other tonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guido Iozzi Husband 21222 6801 Brentwood Avenue, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Dundalk, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 18, 2011 Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. L nly one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician/ una disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Unknown g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 🗎 No 3 🗌 Probably 4 **X**Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 🗌 No Accident Investigation To the Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Checl alfying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Sigr ature and title of ertifie 29d. Date signed (Month, Day, Year) 11-11-11 00071287

Registrar

DHMH 17 Rev 06-2011

State

N. Charles St. Suite 4105, Balthream, MU 21204

Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2011

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36316 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Jakovics 0025 November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HospitaL Novinwest Baltmire andallstm 8. Date of Birth (Month, Day, Year) May 9, 1945 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Czech Republic **Director** 66 213-46-3007 May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Hunt Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 USA 11 Warren Lodge Court 2C 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 X Yes 2 No 1967

If Yes, Give Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 1973 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Sales Liquor Distributor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Walter Jakovics Slegelis Severa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Hallocks Mill Road Yorktown Heights, NY 10598 Mara S. Ziedins, Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/14/11 Baltimore, Maryland Signature of Funeral Service License Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASUVD Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Day 4 Pregnant Pregnant at time of death been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural 5 Pending n 24 hours and he Funeral Director: Aff Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D72317 November 12,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Old Conrt

Registrar's Signature

MD

5 2011

Road

Randallstmm, hp 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Helen V. Jackson November 8, 2011 1:25p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 🗆 M 2 🕱 F 099-20-3442 Virginia Yrs Director 22. 1921 Jan. Usual Residence of Decedent 10b. County N/A 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director with the Maryland State D C Washington 1 K Yes 2 No 10f. Zip Code **20016** 10g. Citizen of What Country?
United States ö 10e. Street and Number 3617 38th Funeral Street, NW items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by "natural", or 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 72 hours after Black 1 ☐ Yes 2xxNo Specify 3 X Widowed 4 ☐ Divorced Specify. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Dental Office Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Blanche Harmon John Addison 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State. Zip Code) Sth Street, NW, Washington DC 20016 19b. Mailing Address (Stre 3617 38th permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau once, John H. Jackson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/15/2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Of Heaven Cem. Gate Signature of Funeral Solvice Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 U Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute minutes disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Director: / Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co No 68488 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEIR Irwin MD 9901 Medical Car Dr

State

Registrar

Date filed (Month, Day

NOV 1 5 2011

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death November 13 Physician/ 3:48 PM ROBERT JENNINGS 2011 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore washington Medical Center BUCNIE Anne 61en Arond If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 XX 2 - F Days Hours Min Aug 29, 1950 Director 214-54-1755 61 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2xx No MD Glen Burnie Anne Arundel 10e Street and Number 9 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be Funeral items 23a 113 Alview Tr. 21060 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, med Forces? Black, White, etc. 1 Never Married 2 XMarried ō þ 1 XXYes 2 No If Yes, Give Year or Dates. 21215-0036 1 ☐ Yes 2XX No Specify: than "natural", 3 Divorced Specify: White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within a Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 UPS Maintenance Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ injury or other traumatic Robert Donald Jennings Ann Patricia Kozlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia L. Jennings Wife 113 Alview Tr., Glen Burnie, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify Cedar Hill Cemetery Nov 17, 2011 Brooklyn, MD 21. Sign (un) of Funeral Survival . Name and Address of Facility
Fink Funeral Home, P.A. K. Gregory M01148 426 Crain Hwy S., Glen Burnie, MD 23a. Part 1. Enter the disease or or shock, or heart billure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Immediate Cause (Final and Death Ph, sician/ ANOXIC BRAIN INJURY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MOIT SURTING PAWAIA ASPAU Sequentially list conditions, if any, leading to manediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi AIDAH9PO ZYRAR Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the signed to be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ ORAL CANCER 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed this certificate 2 🔀 No Yes 25. Was case referred to medica 26. Place of Death (Check only one, Be examiner? Other: 1 🗌 Yes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at After 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No n 24 hours after death e Funeral Director; A eleted filled in by the fi ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29c. License number 29d. Date signed (Month, Day, Year) Californes José Grang NIF53000 NOREWBER 13, 5011

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Registrar
DHMH 17 Rev 7/2009

State

GIANGRECO 301 HOSPITAL DRIVE, GLEH BURNIE, MD 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-08420 State of Maryland / Department of Health and Mental Hygiene Robert Michael Kennedy 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 9, 2011 1256 hrs **Medical Examiner** Michael Kennedy Robert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Worcester Atlantic General Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Foreign Months Davs Hours May 23, 1957 Director effffsvlvania 54 228-92-8250 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Virginia Beach es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a.f sho Virginia Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 23452 633 Kings Grant Road 14 Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married 2X No Yes Specify: White 1 Yes 2 X No specify: 4 X Divorced If Yes, Give Year ۵ 16b. Kind of Business/Industry East Coast 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hydrographic timore, MD 21215-0036 Self Employed 12 Surveyors 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosemarie Louise Ritter Robert Joseph Kennedy Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) မ 633 Kings Grant Rd., Virginia Beach, VA 23452 Robert Joseph Kennedy (Father) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Eastern or strebblee) 2 Cremation 3 Removal from State 1 X Burial 11/12/2011 Virginia Beach, VA Chapel Cemetery 4 Donation 5 Other Specify: 22.Name and Address of Facility H.D. Oliver Funeral Apts, Inc. 2002 Laskin Rd., Virginia Beach, Signatury of Funeral Service Lice VA 23454 ine Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and led for use as the burial - transi Physician/Medical AMENDED UNPENDED Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death signed by the attending be detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ğ 1 Yes 2 V No 3 Probably 4 Unknown Completed ficate has been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy After this certificate has performed? 2 No ✔ Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. Be Other Nursing Home 5 Residence 6 Other 1 Yes 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death Nov 9, 2011 Certification: Precipitated out of boat 1200 hrs 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ✓ Yes 2 No Pending 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide or Town, State) Rt. 611 S/0 Verrazano Bridge, Assateague Island, MD determined (Specify) Ocean 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCMF 2006

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Carol Allan, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

OCME

32. Registraris Signature

ORIGINAL

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

November 10, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ 5:28 AM Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (Lobt institution, give street and number) Examiner -9 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Sex 1

M M 2 □ **Funeral** April 16,1920 Months Days Hours Min Mary land 216-09-9512 91 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location Director 1 🗌 Yes 2 😾 No M Lochern Balto. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21207 6811 Campfield Road death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 1. Marital Status Armed Forces 1 Never Married 2 Married δ 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: white 3 Divorced 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12th Manager injury or other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Christina Hammel Kruelle Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nottingham, Md. 21236 19a. Informant's Name/Relationship (Type, Print) Mina Reiter Niece 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 11-15-2011 Timonium, Md. Dulaney Valley 4 Donation 5 Other (Specify) 22. Name and Address of Facility Miller Dippel Funeral Home, Inc. of Funeral Service Licensee 21. Signatu 6415 Belair Road Baltimoe, Md. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) the Unknown P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes Certificate: 28d. Describe how injury occurred injury 2 Accident 1 Natural 5 Pending 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pith Year) 31. Date filed (Month, Day, Registrar's Signature State Registrar NOV

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 7:40 AM November 12, 2011 Frances Lorraine Kornse /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunny Acres Assisted Living North East If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/12/1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Pennsylvania Director 179-22-4452 81 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location show rthan "natural", or items 23a or 28a-f sho the Midlical Examiner must be notified at 1 Yes 2 No Director MD Cecil Earlville 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 40 Bluff Road 21919 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Completed by 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) 9 Own Home Homemaker .. Pages 1 and 2 should be filed w tment of Health and Mental Hygien tant: If Item 27 is marked other ti jury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McDevitt ဂ္ Mary John Paul McDevitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Martin / Daughter 40 Bluff Road, Earlville, MD 21919 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Buriai 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 11/14/2011 Hanover, Maryland 4 K Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature Funeral Service Leensee Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Inal Due to (or as a consequence of) /Medical Examiner 07 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IE FEMALE esn 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate 1 Yes 2 No Hospital or Attending Physician: After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Living 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred fnjury 1-Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide the Funeral Direction of filled in 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 5 2011 Darks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Dr. Madhu Sachder

322 E. Cec.

DO026183

29d. Date signed (Month, Day, Year)

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and the same	Medic Examin		Mary Marg 4a. Facility Name (if not institution, gi	ye street and number)	II		4b. City, Town, or Loc	ation of Death	Novemb		. County of D		4 A M
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	Funeral Director		5. Social Security Number 217–18–2613 Usual Residence of Decedent						9. Birthplace (State or Foreign Country) Maryland				
	/land f show ed at	to	10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside	
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0214	h with th ns 23a o nust be	Funeral Director	1100 Iron Bark	t F		10f. Zip Code 21015			10g. C	l0g. Citizen of What Country? US			
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	hysician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	mplications that caused one cause on each line	? .							Approxim Interval B Onset an	etween
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P.O. Box 68760	been signed by the attending physic should be detached for use as the b.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 🗀 Fetal o	death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day	Year
	gned by	한 면 한	Part II. Other significant conditions	contributing to death be	ut not result	ting in the un	derlying cause given in	Part I.	23e. Did to	obacco	use contribute	to the cause of	death?
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Division of Vital Records,	within 24 hours after death. To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should be	Completed							24a. Was autor perfo 1 ☐ Yes	osy ormed?	prior t death	autopsy finding o completion of ? /es 2 PNo	
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Tot	To 1		29b. Signature and title of certifier with the will be the signature and title of certifier with the signature and title of certifier with the signature and title of certifier and cer	chant			29c. License num D 63				te signed (Moi	nth, Day, Year)	011
N			80. Name and address of person who Sid Z. Ichar	completed cause of de	eath (Item 20	3a) (Type, Pri							
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. Within E4 hours after death this certificate has been signed by the attending physici To the thereal Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	M 1 ☐ Yes	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office				
_	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Examin	cian: To the best of my knowledge, death occured at the time, dater: On the basis of examination and/or investigation, in my opinion, d	death occurred at	t the time, date and pla	ice, and due to the	cause(s) and manner stated.	
	To the within 2 To th e comple	ž	only one) 3 Certifying Nurs 29b, Signature and title of certifier	Practioner: To the best of my knowledge, death occurred at the time. 29c, License nut			se(s) and manner as Date signed (Mant		
9	190		1 Mmm	VIV DS7	77+		11041	(
	. Dr.		November B.	empleted cause of death (Item 23a) (Type, Print)	roods	Road. M	102123	.4	
ı	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5 2011	32. Registrar's Signature	31			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:25PM Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore San down-Winchester uture Care If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** Country) Mar Days Min Month, Day, Year 1 🗆 M 2 🖭 F Yrs. Director rland Usual Residence of Decedent 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 No Marylana 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral Gilmor and Mental Hygiene. is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) within 72 hours after death Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Completed by 2 No 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Margare permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke, any injury or other traumatic é randdaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GWYNNOa KAVE, 20a. Method of Dispositi 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Catensville, Maryland 4 Donation 5 Other (Specify) remator 21. Signature of Funeral Service Licensee, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MO STAG PISEASE KIDNS disease or condition Medical resulting in death) Examiner HYPERTEN SIVE CARDIOVAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) as been signed by the attending physician and 2 should be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop performed / 2 No this certificate has page To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 2 No 25. Was case referred to medical **Division of Vital** funeral director. æ 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural _____atural

Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) DW59107 11-12-2001 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21136 Busness CENTER DRIVE 32. Registrary Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charlotte Lightner 2:35 PM November 9 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 218-22-2252 **Director** 1 🗆 M 2 💢 F 88 Yrs. Dec 4, 1922 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Completed by Funeral Director 1 Yes 2 No Maryland Baltimore Parkville 10e. Street and Numbe 10g. Citizen of What Country? items 23a 7709 Chestnut Avenue 21234 USA and 2 should be filed within 72 hours after death . Health and Mental Hygiene. tem 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗓 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Packing Clerk Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard Boehm Irene Florey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7709 Chestnut Avenue Parkville, Maryland 21234 permit. Page 1 and 2 Department of Health Important; If item 2: any injury or other toonce, Laura Nash, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 11/11/11 Baltimore, Maryland Signature of Funeral Service Licer Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ aitonit disease or condition web (Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) MUSPLE 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Dath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 3 Suicide injury 5 Pending work? 2 🗌 No Investigation Accident after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complete only one) 29b. Signature and title of cel 29d. Date signed (Month, Day, Year, 13 romsel

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHATURS

MV)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 1230 AM REGINA B. LANG November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockspring Village Forest Hill Har ford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country)
 New York 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Funeral Days 1 □ M 2 🖊 F Director 134- 14- 0983 86 03/20/1925 Usual Residence of Decedent 28a-f show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bartment of Health and Mental Hygiene.

Nortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Forest Hill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Colgate Drive 21050 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Mitchell Florence VanAlstyne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Lang- Son 1104 Glastonbury Way Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Atlantic Crematory 11/15/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of Bel Air 610 W. MacPhail Rd. Bel Air, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ Lung Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Emphysema 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2. No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work hours after death. neral Director: Aft d filled in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ertifying Physicie : the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number H0654439 November 14,2011 30. Name and ress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

NOV 1 5 2011

incent A Giminary Do 2012 Toll gate Road . * 111 TSel Air, mis 21015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36328 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 8:40 PM Michael Leroy Landaker VOL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington <u>18817 Eliason Way</u> Hagerstown 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funerai Days Min. 1 XM 2 □ F Hours (Month, Day, Year) 10/29/1947 Country) Maryland Director Yrs 214-46-7313 64 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 18817 Eliason Way 21740 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Seese James William Landaker Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12414 St. Paul Road, Clear Spring, MD 21722 Farrah Landaker-Palmer/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 11/14/2011 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the dilease, or or mplications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Due to (or as a consequence of physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No a Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 2 N Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1-Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO0245031 2011 u NOU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDDICUM ND Julistan 1 (Month, Day, Yea, 1 1 5 201 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Day Physician/ 2011 2:50 George Wilfred Gardner Lopez, Jr. November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, March 29, Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** New York Days 1 🔀 M 2 🗆 F Hours **Director** 63 191-36-7612 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County at 10c. City. Town or Location death with the Maryland Director r 28a-f sl notified 1 🗌 Yes 2 🛣 No Silver Spring Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ms 23a or must be r Funeral United States 20910 10 Devon Road items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Deceden 2. Armed Forces?
1 ☐ Yes 2 ▼ No er than "natural", or iter the Medical Examiner Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify Specify: Black 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Ith and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) NBC Sound Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item Z7 is marked can jujuy or other traumatic eve once. ပ Elinor Louise Drake George Wilfred Gardner Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11328 Narrow Trail Terrace, Beltsville, MD 20705 <u> Alice H. White/Friend</u> Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition November 13. cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium. 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Inc 21. Signatu of Funeral Service Licensee A Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Severe Cardiomyopathy Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physiciar Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Kidney Disease autopsy has Yes 2 X No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 은 1 Ninpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at work? 1 Yes 2 No n 24 hours after death.

e Funeral Director: After tholeted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d Describe how injury occurred injury 1 X Natural 5 \square Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 24 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year) November 7, 2011 D0063343

State Registrar

12

Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Trina Ruban
1500 Forest Glen Road, Silver Spring, N

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Thomas Michael Loughney November 10:35 PM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 3310 North Leisure World Blvd. #631 Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 165-20-7896 Director 1 X M 2 🗆 F 83 December 9, 1927 Pennsylvania ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3310 North Leisure World Blvd. #631 20906 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces? 1945-Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: "natural" Completed 3 Widowed 4 Divorced 1947 Specify: White Year or Dates th. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Logistics Engineer Department of Defense or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Loughney Margaret Carroll 19a. Informant's Name/Relationship (Type, Print) 20906 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen D. Loughney /Wife 3310 North Leisure World Blvd. #631, Silver Spring, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) November Harveys Lake, Perrego Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 14, 2011 Pennsylvania 21. Signature of Funeral Service Ligenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 MystetteBarrent M01305 23a. P. 11. Friter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot or heart failure. List only one cause on each line. Interval Between Onset and Death Months Immediate Cause (Final Physician/ Hepatocellular Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last burial-tr Due to (or as a consequence of) physician sthe buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cirrhosis Non Alcoholic Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
Yes 2 X No 1 Yes 2 No Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and due to the cause of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartilling Nurso Frantitioner To the basis of my knowledge shall occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D40216 November 8, 2011 20×1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7625 Wisconsin Avenue, Bethesda, Maryland 20814 Dennis Cullen, M.D.

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Mo.

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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:48 Physician/ Richard Allen Liberman 10, 2011 Ам November Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner Howard Columbia Gilchrist Hospice 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Months Davs Hours May 15, 1932 Washington, D.C. 79 579-40-8630 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director Columbia 1 Ves 2 X No Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Ocean Way 8820 Shining Oceans Drive #414 21045 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates 1953–1956 Specify: White "natural", Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Communications Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic eve ပ Dorothy Kolker Carl Liberman 19b. Mailing Address (Strepedam by Bural Route Number, City or Town, State, Zip Code)
8820 Shining Oceans Drive, #414, Columbia, MD 21045 19a. Informant's Name/Relationship (Type, Print) Ina Carole Liberman/Wife Date 13, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Nov. Date 2011 Judean Memorial
Gardens 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral S ce Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final 'ARDIOMUO Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ō Pregnant at time of death 9 Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown THROAT CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an EMPHYSEMA has performed? Yes 2 No page 1 Yes 2 No DEMENTIA 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury_at Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 🔀 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64395 NOVEMBER 10, 2011 CEDAR LANE COLUMBIA, MD 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 DANIEUE DOBERMAN, MD

State Registrar 31. Date filed (Month, Day, Year)*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 12 **Physician** November 2011 Shirley (ana /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2X F December 20,1919 Maryland 215-14-8757 91 Director Usual Residence of Decedent 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Dundalk Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21222 1806 Tyler Road Funeral Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Yes 2 No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify: þ 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Housewife 12 years 2 vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hettie Johnson Charles Shaw Pages 1 and 2 should ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1806 Tyler Road, Dundalk, Maryland permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau Daughter Elizabeth Geci 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20a Method of Disposition Baltimore, Maryland Bayview Crematory 14, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Se of Lice Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, Md. M01176 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3a. Part Immeriate Cause (Final Freilwe Respirator 1 days **Physician** resulting in death) /Medical Due to (or as a consequence of) 4 days Examiner Strake Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events burial-trar and Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Live birth 2 Fetal death Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ģ 5 Other (specify) Pregnant at time of death ed by the at detached t 9 Illnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I þ 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? Yes 2 No has 1 🗌 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \(\sum \) Nursing Home Hospital: 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient з 🗌 DOA ည this 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of completely filled in by the funeral 27. Manuer of Death Certification: or Attending 24 hours after death. Funeral Director: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical onel and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce 12 2011 NES-000 cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 4940 Eastern Avenue, Baltimore, MD, 21224 onica 32. Registrar's Si 31. Date filed (Month, Day, Year) barke State NOV 1 5 2011 Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:00 PM Moore Medical 17 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gene NA Homewood Baltimore 8. Date of Birth (Month, Day, Year) 5 /21 / 68 **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1 M 2 AF 218-82-135 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Mills Owings 1 Yes 2 No 10e, Street and Number 10a. Citizen of What Country? Deer Park 21117 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married p Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic everonce. ၉ Edwar OOCE 19a. Informant's Name/Relationship (Type, Print) (Uncle) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willia Kobes 406 S 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State rinity Cemetery Balto 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Full eral Service Licensee retelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 🗆 No Certificate: To Be Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☑ No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manne Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certile 29c. License number 29d. Date signed (Month. Day, Year) D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittal Praya and 8813 Worth am wood 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Tirhe of Death 1. Decedent's Name (First, Middle, Last) Day Physician /Medical November 09 2011 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) North Carolina 8. Date of Birth 9 (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 241-52-1187 Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show 10b. County notified at 1 des 2 □ No Director -28a-f toro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code or items 23a or must be 376 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑No Baltimore, Maryland 21215-0036 Specify þ Specify. 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto. 2200 21213 Biddle lane 16 20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem 20c. Location 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2 Cremation Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ra North 23a. Part 1 Enter the disease, a complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arres Immediate Cause (Final disease or condition resulting in death) **Physician** TL277 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tyes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 2 🗌 No 1 Tyes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: 1 \square Inpatient Other: 4 \(\sum \) Nursing Home 2 No 2 ER/Outpatient 1 Yes 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending P. hours after death. uneral Director: After t 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

W

Medical

(check only one)

29b. Signature and title of certifie

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2VS 3:10 en November 70 i Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12abeth Nursing altimor Cente If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. If Under **Funeral** Min. Sept. 13,1920 Months Days Hours 1 M 2 7 F 217-34-2794 94 Nebraska Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8720 Ridge Road 21043 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Deceden Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker should be filed with and Mental Hygien 7 is marked other th Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Albert Hanson Lottie Berst permit. Page 1 and 2 should be Department of Health and Merr Important: If item 27 is marke any injury or other traumatic or injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Bearden-Daughter 1301 Tar Cove Road, Pasadena Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Marriottesville MD Crestlawn Mem Gardens Nov.12.2011 21. Signature of Juneral Service Lice 22. Name and Address of Facility Ambrose Funeral Home of Lansdown Hammonds Ferry Road Lansdowne Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each <u>the</u>. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown g | Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 2 X No 3 Probably 4 Unknown Completed 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an men has page 2 autopsy performed? Yes 2 No this certificate Fdema 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed caus e of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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32. Registrar's Signature

wo

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	4	For State	State of Mar				Mental Hy	giene	
		Registrar 1. Decedent's Name (First, Middle,	Last)		Certificate of L	Jeath	2. Date of Dea	Reg. No.	3. Time of Death
Physician/		Paul W. MacEwe	,				Novem	ber & Zol	111200
Medica Examiner		4a. Facility Name (if not institution, s St. Agnes Hus	give street and number)		1 0 ./1	r Location of Death		4c. County of Dea	th
Funeral Director				n yrs. last birtho	lay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat Dec 19,	h g. Bi	rthplace (State or Foreigr ountry) aryland
nd at	. h	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	or Location		•		10d. Inside City Limits
he Maryland or 28a-f sho notified at	ec10		imore	•	ansdowne				1 ☐ Yes 2 🗓 N
a or 28	ב <u>ֿ</u>	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
ms 23	Funeral	2963 Bero Road	12. Was Decedent Eve	riplic	13. Was Decedent of H	1227	pecify Yes or No-	USA 14. Race - Am	orican Indian
0 1.5	[₫	 11. Marital Status 1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced 	Armed Forces?)	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puert	o Rican, etc.)	Black, Whi	te, etc.
2 hour	Completed	15. Decedent (Specify only highes		1 (0	ecedent's Usual Occup	during most of wo	rking	16b. Kind of Business	Industry
rithin 7	5 3	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ti.	fe. DO NOT use retired) ${\sf Tailor}$			Clothing	Industry
filed wall Hyging of other went,	8	17. Father's Name (First, Middle, La	est)			Į.		Maiden Surname)	
rylan uld be fi uld be fi undratal marked natic ev	<u> </u>	Donald MacEwen					ie Crome		
Mal		19a. Informant's Name/Relationshi Judy M. MacEwen						r, City or Town, State, Z $ m yland~2122$	
nore, age 1 and ant of Hea nt if item / or other	-	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.	3 ☐ Removal from State	20b. Place of D	Disposition (Name of crematory or other place of Crematory I	ce)	Date /11/11	20c. Location - City of Baltimore,	r Town, State
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examonce.		21. Signature of Funeral Service Lice						land, Inc.	
	+	23a. Part 1. Enter the disease, or o shock, or heart failure. List or	complications that caused the	ne death. Do no					Approximate
Physician/		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line.	asive s	hock				Interval Between Onset and Death
Medical Examiner		resulting in death)	a. Due to (or as a c	onsequence of	: 1				2 0
	<u>.</u>	Sequentially list conditions, if any loading to immediate cause. Enter Underlying	b. Due to or as a c	onse uence of	:				~ days
xecuted and al-transit	amil	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c						
760 cate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as a o	onsequence of	r:				
8760 tificate bung physic as the bung physic	Med	IF FEMALE:							
Records, P.O. Box 687 The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as the constituted by Divisional Medician Medici	ysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date of d Month	elivery Day Year
P.O. that the ned by a detacl	y Pn	Part II. Other significant condition	ns contributing to death but	not resulting in	the underlying cause g	iven in Part I.		obacco use contribute	_
Records, The law requires are has been signage 2 should by	Ted						1	Yes 2 ☐ No 3 ☐	
law re has be	mple mple						24a, Was auto perfo	psv prior to	utopsy findings availab completion of cause o
II Re in: The ifficate or, pag	3	25. Was case referred to medical			26. F	Place of Death (Che		ormed death? 2 No 1 1 Y	es 2 No
Vital hysician; his certific	ă	examiner? 1 ☐ Yes 2 🗷 No	Hospital:	t 2 🗆 ER/Out	patient 3 DOA Oth	er.		dence 6 Other (Spe	ecify)
ing Pt	2 │	OZ Manner of Death	28a. Date of injury	28b. Tir	me of 28c. Inju ury wor	k?	28d. Describe I	now injury occurred	
	ate: 10	27. Manner of Death1 Natural 5 □ Pending	(Month, Day,	rear) inj					
or Attend after death Director: A in by the fi	Certificate: 10		ation at be	- At home, farr		Yes 2 No	28f. Location (City or Tox	Street and Number or F vn, State)	ural Route Number,
Division Hospital or Attend 24 hours after death Funeral Director: \(\textit{P} \)	Certificate:	1 Matural 2 Pending Investig Investig Could n determin	g (Month, Day, ation not be ned 28e. Place of Injury building, etc. Physician: To the best of maxaminer: On the basis of examiner.	- At home, farm Specify) y knowledge, domination and/or	M 1 C	e, date and place, ion, death occurred	City or Too and due to the ca at the time, date	vn, State) ause(s) and manner as seand place, and due to the	tated. e cause(s) and manner s
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director P Completed filled in by the fi	Medical Certificate: 10	1 Natural 5 Pending Investig 6 Could n determin	(Month, Day, ation ation to be need 28e. Place of Injury building, etc.	- At home, farm Specify) y knowledge, domination and/or	M 1 C	e, date and place, ion, death occurred he time, date and p	City or Too and due to the ca at the time, date	vn, State) ause(s) and manner as seand place, and due to the	stated. e cause(s) and manner si as stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	1 Natural 2 Pending Investig Could n determing Check 2 Medical Exonly only one) 3 Certifying	g (Month, Day, ation not be ned 28e. Place of Injury building, etc. Physician: To the best of maxaminer: On the basis of examiner.	- At home, farm Specify) y knowledge, domination and/or	M 1 C n, street, factory, office eath occured at the tim investigation, in my opin dge, death occurred at t	e, date and place, ion, death occurred he time, date and p	and due to the call at the time, date a lace, and due to the	vn, State) ause(s) and manner as s and place, and due to the cause(s) and manner a	stated. e cause(s) and manner st as stated. hth, Day, Year)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide Could n determin 29a. Certifier (Check 2 Medical Exonly one) 3 Certifying 29b. Signature and title of Certifier 30. Name and address of person was considered in the constant of the constant o	(Month, Day, ation to the head of the head	- At home, farn Specify) y knowledge, dimination and/or set of my knowle	m, street, factory, office eath occured at the tim investigation, in my opin dge, death occurred at t 29c. Licens N/	e, date and place, ion, death occurred he time, date and p se number	and due to the call at the time, date a lace, and due to the	tuse(s) and manner as and place, and due to the cause(s) and manner and the cause(s) and manner and the cause(s) and manner and the cause(s) and manner and the cause(s) and manner and the cause(s) and manner and the cause (s) an	stated. e cause(s) and manner st as stated. tth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month /2 Day 4:00 PM Physician/ JAMES L. 2011 MOSLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BATIMORE ALICE MANOR Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months 216-20-7147 **Director** 1 🗙 M 2 🗆 F 84 Yrs. MD 09-18-1927 10d. Inside City Limits 28a-f shov 10c. City, Town or Location Department of Health and Mental Hygiene, Important; or items 23a or 28a-f sho Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 GILCREST COURT 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) GENERAL MOTORS College (1-4 or 5+) Elementary/Secondary (0-12) ABOR UNION OFFICIAL 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17._Father's Name (First, Middle, Last) GLADYS CROWNER JAMES MOSLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1100 GILCREST COURT. PARKVILLE, MD 21234 19a. Informant's Name/Relationship (Type, Print) of Health a LEAH WHITE (DAUGHTER) James 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 11/18/2011 LAUREL, MD MD NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE PUNERALSWS Signature of Funeral Service Licensee YORK ROAD. BALTO, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a cosequence of). disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Unidenting Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page 2 performed death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No s after death. I Director: Aft Investigation 6 Could not be filled in by the 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 3 □ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title, certifie D31464 MD 1114111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAN STSME 308 BALTIMORE MUZILO HAS AMI MD 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 6115 517 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** Baltinore HOLLITA BOTTI HOLD 2550011 If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 216-30-0205 03-10-1935 1 🛛 M 2 🗆 F Months Hours Min. Country) MD Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director MP BAUTIMORE 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 33rd 21218 USA E. STREET permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked when any injury or well. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 XNo Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry CONSTRUCTION Elementary/Seconday (0-12) College (1-4 or 5+) BRICK LAYER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ REVA BURRIS MINTER EDWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN MINTER BATTIMOTE, MD. 21218 1208 E. 33rd ST. (WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of ,/23⁷2011 Kanetery, Memior of ether place) 1 Surial 2 Cremation 3 Removal from State BATIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SUS 21. Signature of Funeral Ser (ice Densee YORK ROAD. BALTO, MOITS MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition LOM ¬Ph sician/ ObiTructive ואונונוף /ט ו C121 Medical resulting in death) Due to (or as a consequence of) Examiner THEO MINIG Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) Yes 4 ☐ Pregnant 9 ☐ Unknown signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □ Unknown Division of Vital Records, 2 🗌 No 1 🗌 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 page 2 s has death? 24 hours after death. Funeral Director; After this certificate 1 Yes 2 No 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛱 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA မှ 1 Yes . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 💥 Natural injury 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide upleted filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I 29b. Signature a 29d. Date signed (Month, Day, Year) ρ 400 g 0. Name and address of person who completed caus of death (Item 23a) (Type, Print) 101811 1000 WI BelT, ADIL Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 12, 2011 Walter Campbell 9:00 PM Massey Jr. Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Wheaton Wheaton Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)Alabama May Tay 13 Months Days Hours Min. 68 Director 423-56-3293 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Tes 2 X No Montgomery Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11901 Georgia Avenue U.S.A. 20902 should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Widowed 4 N Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Editor Newspaper Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Walter Campbell Massey Sr. Lorine Culp ige 1 and 2 should be nt of Health and Mer t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion M. White - Sister 4307 Willoughby Ct. Chantilly, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Buriel 2 A Cremation 3 Removal from State Conation 5 C Other (Specify) Metropolitan Crematory 11-15-11 Alexandria, Virginia 22. Name and Address of Facility Pierce Funeral Home 9609 Center St., Manassas, VA 20110 21. Signature of Funeral Service Lige un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NFRACTION MYDGARDIAG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician by Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year 4 Pregnant 9 Unknown Day Pregnant at time of death ned by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be c Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 2 this certificate 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 X Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation filled in by the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State Registrar

NOV 1 5 2011

Merlyn Vemury

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

9801 Georgia Avenue, Suite 227, Silver Spring, MD

29d. Date signed (Month, Day, Year)

20902

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	Please			d / Dep	ndelible Ink artment of H rtificate of D	lealth an			gible.	36341
Physicia Medic		1. Decedent's Name (First, ELIZABETI	S. MC	NUL T Y					2. Date of De Month 1 1	Day 1	() Year 11	3. Time of Death 4:07 P M
Examin	ier	4a. Facility Name (if not ins WALTER REEL				MEDIC	4b, City, Town, or AL BETHE	Location of De ESDA M			nty of Death ONTGOM	ERY
Funeral Director		5. Social Security Number 076-12-7419 Usual Residence of Deced] M 2 🛛 F	7. Age (In yrs. la 92	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Irs. 8. Date of Bir lin. June 3	th iy, Year919	9. Birthpl Count S1	lace (State or Foreign ryMyjava ovakia
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The proportions if it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		County	N.W.		, Town or Lo				10g. Citizen (of What Count	0d. Inside City Limits 1 ☒ Yes 2 ☐ No try?
ours after death atural", or items cal Examiner mu	by	11. Marital Status 1 Never Married 2 3 Widowed 4 Di	☐ Married	Armed Force 1 Yes If Yes, Give Year or Date			Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🖾 No Ident's Usual Occupa	Specify:		Spec	Race - America Black, White, e Sify: Whit	etc.
within 72 h rgiene. ner than "na t, the Medic	Completed		ly highest grad		1 or 5+)	(Give life. L	kind of work done do OO NOT use retired) memaker		working	Own I		ustry
uld be filed I Mental Hy narked oth natic event	To Be	17. Father's Name (First, M Pavel Sivac 19a. Informant's Name/Re	ek	B : 0		T		Kater	Name (First, Middle, ina Dudak			
nd 2 sho ealth and n 27 is i		Colleen L.		e, Print)			ing Address (Street a Wedgewood					ode)
. Page 1 ar ment of H tant: If iter iury or oth		20a. Method of Disposition 1 \(\bar{\Delta} \) Byrial \(2 \cap \) Cref 4 \(\bar{\Delta} \) ponation \(5 \cap \) (mation 3 🗆 F Other (Specify)		State C	emetery, cre	osition (Name of matory or other place d Cemeter		Date 1/19/2011		on - City or To	
permit Depart Import any inj once	į	21. Signature of Funeral Se	15	Hum	Zin .		2. Name and Addres rexler Fu 625 W. Hi			entown	, PA 18	3102
Physician/ , Medical		23a. Part 1. Enter the dise shock, or heart failure Immediate Cause (Final disease or condition resulting in death)		cause on eac		n. Do not en Λ		_		rrest,		Approximate Interval Between Onset and Death
s be executed sician and solution and solution and solution and solution are solutions.	ical Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	s, te	Due to (o	r as a consequ	ence of):						
To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the long physician by the funeral director, page 2 should be detached for use as the long that the funeral director is a should be detached for use as the long that the funeral director is a should be detached for use as the long that the funeral director is a should be detached for use as the long that the funeral director is a should be detached for use as the long that the funeral director is a should be detached for use as the long that the funeral director is a should be detached the long that the funeral director is a should be detached the long that the funeral director is a should be detached the long that the l	Physician/Medi	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	ant 2	Bc. If yes, outc	ant at time of c	Ideath 3	☐ Ectopic pregnanc	у			Date of delive	ery Day Year
quires that then signed by all the detaction		Part II. Other significant c	conditions cor	tributing to dea	ath but not res	ulting in the	underlying cause giv	en in Part I.				e cause of death?
sician: The law rec certificate has bee irector, page 2 sho	Completed by										b. Were autop prior to con death? 1 Yes	osy findings available impletion of cause of 2 🔀 No
sician: certific lirector,	To Be	25. Was case referred to mexaminer? 1 ☐ Yes 2 ☒ No	<u> </u>	ospital:	npatient 2 🗆	EB/Outpetie	Othe	r.	Check only one)	danas C 🗆 C	DAL 10 man 16 1	1
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate: T	2 Accident	Pending Investigation Could not be	28a. Date o (Month	f injury o, <i>D</i> ay, Year)	28b. Time o injury	of 28c. Injury work'	at	28d. Describe	how injury occ	urred	
tal or At rs after al Direc led in by		4 Homicide	determined		g, etc. (Specify		reet, factory, office		28f. Location (City or To		mber or Rural	Route Number,
the Hospi thin 24 hou the Funer mpleted fill	Medical	(Check 2 ☐ Me only one) 3 ☐ Ce	dical Examine rtifying Nurse	r: On the basis	s of examination	and/or inve	death occurred at the	n, death occur time, date and	red at the time, date	and place, and ne cause(s) and	due to the cau I manner as sta	use(s) and manner stated ated.
0 0 Wit		29b. Signature and title of	certifier	3	- m		29c. License		o VA	Nove my	med (Month, E	
12611		30. Name and address of p			of death (Item	23a) (Type,					,	
Stat Registra		31. Date filed (Month, Day, NOV 1 5 201	Year)	32. Re	gistrar's Signat	ure					-	
TH 17 Rev 7/20		7707 1 0 201	· ples	were,	B 100	Med						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jennifer Louise McCabe Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Sbury WICOMIC 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Hours Min (Month Day Year) 08/19/1945 Mary land **Director** 222-30-2137 66 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No Maryland Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral 420 Dighton Avenue 21863 U.S.A. items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status event, the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: "natural" Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Department of Health and Ment Important: If item 27 is marke any injury or other traumatic Dolly Jarvis Tharpe Rhoades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Dighton Avenue, Snow Hill, MD 21863 Ralph McCabe / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/14/2011 Hanover, Maryland Anatomy Gifts Registry 21. Signature of Juneral Service Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final Physician/ HRONIC OBSTRUCTIUR PULMONAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Duc to (or de a consequence of): Exami Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death signed by the and be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death?
1 Yes 24 hours after death. Funeral Director. After this certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No SPICZ ္ဝ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence of Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 14 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature an 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strisbufy up 21802

Registrar DHMH 17 Rev 7/2009

State

WAR

31. Date filed (Month, Day, Year)

NOV 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 201^{rea} November 5:30 A^{M} McClure Frances Lester 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Hours Min. 401-60-3762 1 🗆 M 2 💢 F Yrs. October 10, 1942 **Alabama** 69 Usual Residence of Deced 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 🗆 Yes 2 💢 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9603 Glencrest Lane 20895 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Government Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Maxey Pauline Parrish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 Glencrest Lane, Kensington, Maryland 20895 Charles Hume McClure/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State November 11, 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. the fr 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Ph_sician/ Medical **Examiner**

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f show

ō must be

23a

permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu

Baltimore, Maryland 21215-0036

notified at

Director

Funeral

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Completed

Be

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with the Maryland

Completed by Physician/Medical Examiner use as the burial-transi ĵ signed by the at Id be detached for peen cate has completely filled in by the funeral director, To Be Medical Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition	Ovarian Cancer		Onset and Death
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	One to (or as a consequence of):		
that initiated events c. resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions control	ributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
			<u> </u>
		24a. Was an autopsy performed?	
25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)	
1 Yes 2 X No	spital: 1 TyInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 Yes 2 No	28d. Describe how inju	iry occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
(Check 2 Medical Examine)	ian: To the best of my knowledge, death occurred at the time, date and place, a r: On the basis of examination and/or investigation, in my opinion, death occurred at Practitioner: To the best of my knowledge, death occurred at the time, date and place.	t the time, date and place	e, and due to the cause(s) and manner stated.

29c. License number

Kashif Alam Firozvi, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910-7000

D0064983

29d. Date signed (Month, Day, Year) November 9, 2011

State

To the within 2

10 V

29b. Signature and title of certification

31. Date filed (Month, Day, Year)

NOV 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36344 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 1 WILLIAM JOSEPH MADONNA, SR. 10:45 PM 2011 Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 225 Inlet Drive Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Hours 217 22 8651 **Director** 1 **⊠**M 2 □ F 03 10 1928 83 Maryland Usual Residence of Decedent or 28a-f show notified at 10a, State 10b County 10c. City. Town or Location 10d Inside City Limits Funeral Director 1 Yes 2 X No MD Anne Arundel Pasadena 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 21122 U.S.A. 225 Inlet Dr "natural", or iterr edical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc. p 1 Never Married 2 Married Yes, Give 1946-1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed 1950 White Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel Brick Mason and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Trustt Carlo Madonna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Phyllis Madonna - Wife Inlet Dr Pasadena, 21122 225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ţo. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Important: If any injury or once. Lakemont Memorial 11/16/11 Davidsonville, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Physician/ Probable myocardial disease or condition Medical resulting in death) **Examiner** Congestive heart Lyeur Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 2 42015 Stace Renal Due to (or as a consequence of resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Yes 2 No signed by the a 1 ☐ Yes 2 ☐ Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? After this certificate 1 Yes 2 No Yes in 24 hours after death.

the Funeral Director: After this certifican pletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 021225 11/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Saltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar

808 Landmark Drive #122 Glen Burnie MD

11-08433 Ugochukwu Madu Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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F	hysici		Registrar 1. Decedent's Name (First, Middle	,Last)				_	1	2. Date of De Month		,	3. Time of Death
/ledical	Exami	ner	Ugochukwu		Donald		Ma			Novembe	er 9, 2011		2010 hrs
			4a. Facility Name (if not institution 4300 Edgehurst Road	, give street end num	nber)	1	b. City, Town, Baltimore	or Location	of Death		4c. County	or Death	
F	uneral			6. Sex 7	7. Age (In yrs. I	last birthday)	If Under 1 Y	ear If Und	er 24Hrs.	8. Date of B	irth(MM/DD/YYYY		
	rector		212-77-0629	1X M 2 F	28	Yrs.	Months D	ays Hours	s Min.	03	19 83	Foreig Cou	Najgeria
			Usual Residence of Decedent										
	W any		10a. State 10b. County		10c. City	, Town or Locati							10d. Inside City Limits 1 Yes 2 No
vland	28a-f show I at once,	햦	MD NA 10e. Street and Number			Baltin	10re				10g. Citizen of Wh	nat Cour	22
e Mar	23a or 28a-f sho notified at once.	Director	4300 Edgehurs	st Road				1209			Nige		-
with th	18 23a e noti		11. Marital Status	12. Was Dece	edent Ever in U		Decedent of	lispanic Ori			o- 14. Race	- Ameri	can Indian, Black,
death	or iten	Funeral	1 Never Married 2 X Ma	1 Yes	2 X No	If Ye	es, specify Cub	an, Mexicar	n, Puerto F	Rican, etc.)	White		ack
safter	ral",	ğ		rced If Yes, Give Yeer or Dates:		1 16a. Decedent	22	No specify		- wie alama	Specify: 16b. Kind of Bu		
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036 thin 7	ne. than edical	Completed	12th grade	3yr		5	Studen	t			Coll	ege	
5 O	Hygier other the M		17. Father's Name (First, Middle,	Last)		_		18.Mothe			Maiden Surname		
21215-0036	fental narked event,	o Be	Julius Madu 19a. Informant's Name/Relationsh	in (Type Print)		19h Mailing	Address /St			Amanz	e amber, City or Tow	n State	Zin Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be	욘	Kenneth Aman:				•				ltimore		id 21209
6, 1	Health item		20a. Method of Disposition			Place of Disposi crematory or oth	tion (Name of		<u> </u>	Date	20c. Location -	City or	
Baltimore,	ent of nt: If		1 Burial 2 Cremation 4 Donation 5 Other Sp		III State	ladu Fa			12/	3/201	Umuama 1Mbaise		Omana
alti	partm ports		21. Ign ure of Funeral Service	icensee		22. N	ame and Addr	ess of Facilit	y s t	_			
		is ett	23a. Part I. Ententhe disease, or	2. 7)-c+c	d the death	430	00 Wab	ash A	Ave,	Balti	more, M	ary	land 2121
	sician ecical	0.0	failure. List only one cause	on each line.					zal diac oi	respiratory a	itast shoor, or the	ai.	Between Onset and Death
≟xa	miner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			ication						
		U	Sequentially list conditions,	b									
		Ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	consequence o	of):							1
-	sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):							
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Box 6876(attending phys for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bir	rth	2 Fet	al death	3 Ectopi	ic pregnar	псу	Month		Day Year
OX (attenc for use	sici	1 Yes 2 No 9 Unk	· L	ent at time of de wn	eath 5 Oth	ner (Specify)						
D. B	by the ached f		Part II. Other significant conditi			esulting in the u	nderlying caus	e given in P	art I.	23e, Did	tobacco use contr	ibute to	the cause of death?
P.O.	signed by	d b								1 🗌 Y	es 2 No 3	Prob	pably 4 🗹 Unknown
ords	s peen s	lete				_				24a, Wa auto	ppsy	orior to c	topsy findings available completion of cause of
of Vital Records, P.O. Box 6876(prysician: The law requires that the death crtificate	icate has page 2 sl	Completed										death? ✔ Ye	es 2 No
<u> </u>	his certificate director, page	BeC	25. Was case referred to medical examiner?	Hospital: 1 In		1		Other	•			· ·	
F Cit	er this ral dire	ျ	1 Yes 2 No 27. Manner of Death	28a. Date o	patient 2	ER/Outpatient 28b. Time of Ir		njury at Wor			Residence 6 how injury occur		: Scene
O II O	eath. tor: After the funeral	<u>.</u>	1 Natural 5 Pend	(Month,	Day,Year)	fd 7:53		Yes 2 🗶	- 1		t ingest		rug
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Division of Vital I	within 24 hours after death To the Funeral Director: completely filled in by the			ysician: To the best									
Tot	To t com	Medical	29b. Signature and title of certifier	and manner sta				nse number			29d. Date sign		
			his cus	· ~>			0.0	C.M.E.			November	10, 20	011
220			30. Name and address of person										
pard				t Medical Exam	Dir.			altimore,	MD 212	223			
	S	tate	31. Date filed (Month, Day, Year),	2011 32. Keg	gistrar's Signat	1. Mar	Red						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 08 2011 6:00 A M PHILAMENA MARY NUCCI Medical 4a. Facility Name (if not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** <u>Arundel</u> <u>Anne</u> Pear Tree Assisted Living Pasadena 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Unde Social Security Number If Under **Funeral** Hours Min (Month, Day, Year) 219 22 8778 82 **Director** 1 □ M 2 🔀 F 1929 22 Maryland 04 Usual Residence of Decedent show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 28a-f 1 Yes 2 X No Pasadena MD Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code o 23a Funeral 181 Kenwood Rd 21122 U.S.A. items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? by "natural", or 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced White Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Hair Salon 11 Hairdresser Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I is marked ပ္ Dominic Gilberto Clara Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a 21122 Seamore St 8343 Pasadena, MDWilliam Dowell - Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State ò Important: In any injury or Haven Mem Pk 11/11/11 Glen Burnie, MD Glen 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 21122 Riviera Drive Pasadena, MD 169 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death et and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Day Month 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a, Was an prior to completion of death? certificate has performed Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Ather (Specify 2 440 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work death. 1 🗌 Yes 2 🗌 No eral Director / 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 200 GR.

Registrar

DHMH 17 Rev 06-201

State

Date filed (Month, Day, Year)

death (Item 23a) (Type, Prin

32. Registrar's Signature

Ampleted cause of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Vovember Physician/ 2120AM Medical or Location of Death 4c. County of Death if not institution, give street 4b. City, Town **Examiner** 301 timur WSING 12 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan . 28 , 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Days Hours 1 ☐ M 2XXF Months Mary Land 88 Director 214-18-0611 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5105 Circle Place 21227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 8th n/a <u>Home Maker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nelson Greenfield Anna Bechler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6609 Hunter Road Elkridge, MD 21075 Gloria Wilson/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Suburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery Nov. 15, 2011 Baltimore, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a o uence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) completed filled in by the funeral director, page 2 should be detached for use as the المستخدمة Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death. Director: After this certificate has autopsy perform 1 🗌 Yes 2 🗆 No 1 Yes 2 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) WW 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ CARL CHARLES PRIETZ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Rosedale Franklin Square Hospita 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours 2-2-1932 216-28-8407 1 **Ϫ**M 2 🗆 F **Director** 79 Yrs. Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10a. State 10b. County 10c. City, Town or Location Director BALTIMORE **ESSEX** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 WILSHIRE ROAD 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? ò þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1952-60 Specify: WHITE "natural", 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) FOREMAN POLY SEAL 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 P. PRIETZ WILHELM CONRAD REGINA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 19a. Informant's Name/Relationship (Type, Print) OLD PHILADELPHIA RD JOYCE E. WIMBROUGH/SISTER 8364 ROSEDALE, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 11-15-11 CATONSVILLE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Financial Prince Licensee 1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Povolem Medical resulting in death) Examiner hemic Sequentially list conditions, Ducito (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? 5 Other (specify) 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? by Coronary Artery Disease, Hypertension 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Atrial F. brillation 24a. Was an autopsy filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be xaminer? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗌 No 1 Ninpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Accident Investigation 6 Could not be 2 Accider
3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11-11-201 Res0000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Da

Gopimohan

31. Date filed (Month, Day, Year)

NOV

9000

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

2011

12:15 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

21237

Approximate Interval Between Onset and Death

Baltimore MD 21237

1 Yes 2 XNo

MARYLAND

U.S.A.

State Registrar Franklin

aska

Square Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ivial	ryiand / Depa <i>Cer</i>	tificate of L			Reg. No.			
	A. I	М	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		0.1.	3. Time of Deal	th, 9
	Physicia Medic		Gregary Robert Pre	esley				Novembe	r 7, 20)11	5:10 A	AM
1	Examin		4a. Facility Name (if not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c. County			
4-5			23506 Sugar View I		1	Clarks If Under 1 Year	burg If Under 24 Hrs.	D. Doto of Birth		gomery	lace (State or For	reign
J# -	Funeral Director		5. Social Security Number 6. Sex 217-70-7527 1 D	M 2 D F	In yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day	(, Year)	Count	ry)	eigir
			Usual Residence of Decedent	W Z L F	53 Yrs.			January 8	3, 1958	Texas		
	land show dat	to	10a. State 10b. County	1	10c. City, Town or Loc	ation				10	0d. Inside City Lir	
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21215-0036	rsafte iral", Exar	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🏋 No	Specify:		Specify	Whit	e	
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ary	nd Me nd Me s mar		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a				State, Zip C	Code)	
	d 2 stadth a alth a 27 is		Amy L. Presley/Wif	e		Sugar V						71
ore,	of He of He rothe		20a. Method of Disposition		20b. Place of Dispos			Date	20c. Location			
<u>m</u>	Page nent ant: It		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	demoval from State	Mt. Olivet		ivoveiii	er 11,	Frederi	ck, M	aryland_	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	I AL	1530 R ²² 0	bert A. 0 W. Mon	Pumphrey tgomery	Funeral Ave., Ro	Home, ckville	Rockv , Mar	ville, In	nc. 0850
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	ed sit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	consequence of):					14		
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68 ×	endin r use	Physician/N	23b. Was decedent pregnant	3c. If yes, outcome of	pregnancy Fetal death 3	Ectopic pregnand	ev			ate of delive	*	- 1
Box	death he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at t		Other (specify)			M	lonth	Day Year	
P.O.	at the d by ti letach		Part II. Other significant conditions cor	tributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use con	tribute to th	ne cause of death	1?
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rd	requir seen	Completed						24a. Was	an 24b	. Were autor	psy findings avail	able
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Vita	/sicia s cert direct	To Be	examiner? 1 ☐ Yes 2 💢 No	ospital:	t 2 ER/Outpatier	Oth	er.	lome 5 X Resid	dence 6 🗆 Ot	her (Specify	′)	
of	ig Phy ter thi neral		27. Manner of Death	28a. Date of injury (Month, Day,	28b. Time of	28c. Injur work	y at	28d. Describe h				
on	endin eath. or. Aff the fu	fica	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Yes 2 ☐ No					
Division of Vital Records,	r Atte fter de irecto n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	· - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Num (n, State)	ber or Rural	Route Number,	
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	To the Hospital or Attending Physician; The law requires that the death certificate be executed within £4 hours after death. Of the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Physic (Check 2 Medical Examinonly one) 3 Certifying Nurse	er: On the basis of exa	mination and/or invest	igation, in my opinio	on, death occurred	at the time, date a	ınd place, and d	ue to the car	use(s) and manner	r stated.
	Vithir comp	~	29b. Signature and title of certifier			29c. License			29d. Date sign			
			16cm	2		D3	7142		Novembe	er 7,	2011	
	0		30. Name and address of person who co				1. 477			5.0		
			Geoffrey Coleman, 31. Date filed (Month, Day, Year)				ockville	, Maryla	and 208	JU		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 7:58 Raymond Edwin Pyles November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Year If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday, **Funeral** Director 220-26-2577 1 X M 2 | F March 17, 1924 87 Maryland Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 23a Funeral 20906 United States 11805 Selfridge Road items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. ō 1 Never Married 2 Married X Yes ð 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 X Widowed 4 Divorced Completed Year or Dates. WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Admin Army Reserve Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marie E. Stadtler other traumatic Charles Arthur Pyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Deborah Augustine/Daughter 3801 Shetland Court, Frederick, Maryland 21704 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 23. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2011 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrhagic Shock disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Gastrointestinal Bleeding Secrementally flat or nothing Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury and -trans that initiated events resulting in death) Last Due to (or as a consequence of) the burialphysician Physician/Medical that the death certificate be Box 68760 as t IF FEMALE: use 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown the P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မြ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: XNatural 5 Pending n 24 hours after death.

e Funeral Director: Affeltely filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 2 usse. November 14, 2011 D69288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910-1484 Yodit Negresse, M.D.

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Menth, Day, Year)

NOV 1 5 201

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State		State	of Mar	yland		artment ertificate			and N	/lental Hy		00	n 1 :	1	2621	51
		Registrar 1. Decedent's Name	e (First, Middle	e, Last)			Ç	lincate	UID	eaui		2. Date of De	Reg. N	Evan .		Т	3. Time of Deatl	h
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2	X Cremation	3 Removal from	n State	20b. Pl	lace of Disp	oosition (Name Partory or ot ium, I	e of her place	e) N	ovemb	er 15,	1	Location				
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director and the completed filled in by the funeral director.	Medical	(Check 2	Medical E	g Physician: To the Examiner: On the ba g Nurse Practioner	asis of exai	mination	and/or invi	estigation, in r	ny opinio	n, death o	occurred a	at the time, date	and pla	ce, and d	ue to the	cause	e(s) and manner	stated.
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		For State	State of M		nd / Depa		t of F	lealth and I	Mental Hyo	giene	0011	36352
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Examin		4a. Facility Name (if not institution, g Carriage Hill Nu		er				Location of Death	1	4c.	County of Death	
Funeral Director		5. Social Security Number 199–03–3432	. Sex 7. Ag		ast birthday) Yrs.	If Unde Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Dec • 2	Year) 6, 1	9. Birth	place (State or Foreign ntry) 1 and
aryland a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County D.C.		10c. Cit	y, Town or Loc Wash	cation	on D	.C.				10d. Inside City Limits 1 Yes 2 □ No
with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 4100 Livingston	St. NW			10f. Zip		015		-	tizen of What Cou	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	f Yes, spec	ify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White, Specify: Wh	
ithin 72 hour iene. r than "natu the Medical	Completed	15. Decedent (Specify only highest Elementary/Seconday (0-12)		5+)	life. Do	lent's Usua kind of wo O NOT use	rk done o retired)	ation during most of wor	king		ind of Business Ir	ndustry
d be filed w Jental Hygi irked other itic event, i	യ	17. Father's Name (First, Middle, Las George Fred		Hilt		Oneni	IKCI	18. Mother's Nan Emily			Surname)	ach
nd 2 should ealth and N n 27 is me		19a. Informant's Name/Relationship Gregory B. Rick						and Number or Ru Balttle			Town, State, Zip 49016	Code)
Page 1 arment of Hetant: If iter		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Sp			Place of Dispos cemetery, cren Wartst	natory or c	ther plac	tery Nov	Date .11,2011		ceation - City or T	
permit. Depart Import any inj		21. Signature of Funeral Service Lic	ensee					raT ^{Facili} nd (Ave., Sil				0910
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each line	IORRE	IAGHIC		-	g, such as cardiac		est,		Approximate Interval Between Onset and Death 1 WEEK
	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fet	al death 3 🗌	Ectopic Other (s		су			23d. Date of deli	very Day Year
ires that t signed by Id be deta	þ	Part II. Other significant condition HYPERTEN		out not res	sulting in the u	inderlying	cause giv	ven in Part I.				the cause of death?
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ne Hospi n 24 hou ne Funer pleted fill	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of e lurse Practioner: To the	xaminatio	n and/or invest	tigation, in	my opinio	on, death occurred	at the time, date a	nd place	e, and due to the c	ause(s) and manner stated.
To the Committee of the		29b. Signature and title of certifier homes	Masters	en l	MD	290		e number 0534			te signed (Month,	
10 84		30. Name and address of person wi	·	,		,	DR.	#104, MO	CLEAN VA	2	22101	
Stat Registra	C .	31. Date filed (Month, Day, Year) NOV 1 5 2011	32. Registr	ar's Signa	ture							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e&19h Per FH G921 11/21/2011 All Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BERNADINE ROGERS Month NOVEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE CENTER TIMONIUM BALTIMORE If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-20-8977 85 **Director** 1 □ M 2 🛛 F 8-23-1926 MARYLAND Usual Residence of Deced or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD N/ABALTIMORE CITY 1 X Yes 2 No 10e. Street and Number Leiden ō 10f. Zip Code 10g. Citizen of What Country? must be with 5642 **LEINDEN** ROAD 21206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 8 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည STANISLAUS POPIOLEK BERTHA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad $extbf{dee}$ den no Number or Rural Route Number, City or Town, State, Zip Code) 5642 $extbf{LEINDEN}$ ROAD BALTIMORE, MD 2° BALTIMORE, MD ROBERT J. ROGERS/HUSBAND 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-16-11 BALTIMORE, MD GARDENS OF FAITH 21. Signature of Juneral Servi 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Frantitionar: To the least of my high examined at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 29b. Signature and title of ceptifier 29c. License number 29d. Date signed Month, Day, Year, pleted cause of death (Item 23a) (Type, Print) 101 State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland			of Health and of Death	Mental Hy	/giene Reg. No. 201	36354
		. 96	Decedent's Name (First, Middle, Last)					2. Date of D	eath Day Year	3. Time of Death
	Physic /Med			uhl, Jr.				Novem	nber 8, 201	1 8:00P M
	Exam	iner	4a. Facility Name (If not institution, give s			, ,	wn, or Location of De	ath	4c. County of De	
	-	5 6	665 South Wickham 5. Social Security Number 6. Sex		st birthdav)	Ba Li If Under 1 Y	timore Year If Under 24 H	rs. 8. Date of Bi	Baltim	irthplace (State or Foreign
	Funera Directo	_		TM 005	62 Yrs.		ays Hours Mi		ay, Year) (faryland
	86		Usual Residence of Decedent			1 1		03/27	, 13 13	
	ryian		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	MD Baltimo	re Ba	altimo	re				1 ⊠ Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Co			10g. Citizen of What (Country?
	ath w		665 South Wickham				1229		U.S.A.	
	er de	Funerai		12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Deceden If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or N arto Rican, etc.)	0- 14. Race · An Black, Wi	nerican Indian, nite, etc.
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:		Specify:	White
ô	be filed within 72 hours after death with the Maryland nia! Hygiene. Hourself, or Items 23a or 28a-f ahow event, the Modical Examinational be instiffed at		15. Decedent's Educ		16a, Deced	dent's Usual C	Occupation		16b. Kind of Busines	
15	n "ne	piet	(Specify only highest grade	completed)	(Give	kind of work of DO NOT use i	done during most of w retired)	rorking		•
212	d within gene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Gr	aphic 1	Artist		Printin	g
þ	e filed Il Hygie other	Se C	17. Father's Name (First, Middle, Last)					ame (First, Middle	e, Maiden Surname)	
<u>a</u>	should be fand Mental I amarked of	To B	Robert Carl R	uhl, Sr.			Edith	B€	enson	
Marvland 21215-0036	2 sho and h is ma		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (S	treet and Number or	Rural Route Numi	ber, City or Town, State	, Zip Code)
			Dora Steinberg-Ru						imore, MD	
Baltimore.	pes 1 and 2 should be filed within 7 of Health and Manial Hyglene. If item 27 is marked other than "r		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	1 00	ace of Dispo metery, crer	sition (Name natory or othe	of r place)	Date	20c. Location · City	or Town, State
Ē	Pag ment ant:		4X Donation 5 ☐ Other (Specify)	Ana Ana		fts Regi			Hanover,	
3ali	permit. Pages I Department of H Important: If Ite any Injury or ot once.		21. Signature of Tineral Service License	96					Gifts Regi	and the second second second second second
	707 # 0		1500	/					P, Hanover	Approximate
	Physician /Medical		23a. Part1. Enter the disease, complished, or heart failure. List only in Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	TON			ac or respiratory	arrest,	Interval Between Onset and Death
15	Examiner	Examiner	Sequentially list conditions, taxy, watch you immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	anoa uf):					
68760,	sate be executed obysician and the burial-transit	cal	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
P.O. Box 6	death cert e attendin d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3]Ectopic pregi] Other (speci			23d. Date of o Month	delivery Day Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions con	tributing to death but not resu	lting in the u	nderlying caus	se given in Part I.		tobacco use contribute]Yes 2 ☑ No 3 ☐	to the cause of death? Probably 4 □Unknown
ו טאר I Records,	60	Completed						per	s an 24b. Were opsy prior to death 1 Y	
r & Vital	Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?					eath Check only		
er tof V	\$ w 5	2	1 Tes 2 No	ospital: 1 Inpatient 2 I	ER/Outpatier			Home 5 PRes	sidence 6 Other (S	pecify)
Rode. Division o		ation:	27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c.	Injury at Work? 1 Yes 2 No	28d. Describe	how injury occurred	
Divi	Ital or Attencirs after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, str	eet, factory, o	ffice		(Street and Number or own, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	ledical	(Check only 2 Medical Examilione)	sicien: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death ion and/or in	vestigation, in	my opinion, death oc	ce, and due to the	e, date and place, and o	lue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				icense number		29d. Date signed (Mo	onth, Day, Year)
			Desc-	- KOBAIM)		30494	All all all all all all all all all all	11-9-11	
	->.		30. Name and address of person who co	mpleted cause of death (Item g modicten chot			human mu	10100		
	200	ate	31. Date filed (Month, Day, Year)	/ 32. Registrar's Signat		C 1361	THORE THE	2 (1/12		
	Regis		NOV 1 5 2011		backs	1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 11 Physician/ Barbara Alice Stevens 11 7:55AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Nursing Home Dunda1k Baltimore 9. Birthplace (State or Foreign Country) cial Security Number Date of Birth Funeral 216-32-8032 1 M 2 B Months Hours 75 11/11/87/1936 Maryland Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director MD Baltimore 1 Yes 2 No Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö Funeral 23a 8075 Wallace Rd. 21222 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give "natural", 3 ₩ Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Iem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Donahue Rena Cavey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Stevens/ Son 8075 Wallace Rd., Dundalk, MD 21222 permit. Page 1 and 2 Department of Health Important: If item 2! any injury or other t injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Marriotsville, MD Crest Lawn Cemetery 11/14/11 22. Name and Address of Facility Ambrose Funeral Home 21. Signature of Funeral Service Licenses 2719 Hammonds Ferry Rd., Lansdowne, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death CARDIOVASCULA Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse Was deceded in the past 12 month.

Yes 2 W No . If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 245. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performe 1 ☐ Yes 2 ☐ No certificate 24 hours after death.

Funeral Director: After this certifical effect filled in by the funeral director. 25. Was case referred to pedical To Be 26. Place of Deaty Check only one) examiner? Other: 2 [1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature Wath (Item 23a) Ty Print

State Registrar

Registrar NOV 1 5 201

31. Date filed (Month, Day, Year,

Beneva B. Sparks

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 9, Physician/ 2011 11:00 A M Rosina Squires Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Howard Ellicott Rehabilitation Nursing Home Ellicott City Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) **Director** 1 □ M 2 🗓 F 87 Maryland 219-18-7806 12/23/1923 Usual Residence of Dece 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location Examiner must be notified at Director Elkridge 1 🗌 Yes 2 🔯 No Howard Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 23a Funeral United States 21075 6377 Euclid Avenue "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 X No Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Montgomery Wards Key Punch Operator ge 1 and 2 should be filed w nt of Health and Mental Hygiv : If item 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mauro DePinto ည Libera Salconi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6320 Orchard Club Drive aptartment Elkridge, Maryland 21075 Libera (Lee) Nagal 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 11/12/2011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signatu Fungral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOMES, LLC 1328 Sulphur Spring Road, Arbutus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovascular Alterosclerolic Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnapt 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Year Pregnant at time of death g Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Monknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has death? 1 Yes 2 No Hospital or Attending Physician; The 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗆 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 11 D30641

Registrar

State

DHMH 17 Rev 06-2011

Back River Neck Road balkmore Mayland 2124

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapalli

31. Date filed (Month, Day, Year)

NOV 1 5 2017

201-109

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MITH Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Bulti Mon If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-78-1393 1 ☐ M 2 ☐XFX 38 Months Days Hours (Month, Day, Ye Director Maryland 1973 June Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖁 No Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 205 South Bentalou Street 21223 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. <u>۾</u> 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify:White If Yes, Give Year or Dates Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled 8th Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JoAnne Ace James William Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 South Bentalou St., Baltimore, Maryland 21223 JoAnne Ace - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory, LLC Nov. 13, 201 Glen Burnie, Maryland

22. Name and Address of Facility AMBROSE FUNERAL HOTE, INC. 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee a 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 MUL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final PURLAMIA Ph_sician/ disease or condition resulting in death) WKER Medical Due to (or as a consequence of) <[€]Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to or as a conse and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 ___ retail acc.

Pregnant at time of death Ectopic pregnancy in the past 12 months? Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No ည 1 Yes 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) USTISSEU MD 1006 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:58 P™ Edward Leon Guerrero Salas Jr. November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Harford Memorial Hospital Havre De Grace If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Hours June 7, 1976 Mary Land 1 X M 2 □ F Director 213-90-8834 35 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Havre De Grace Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21078 2303 Nova Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Asian 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene, marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within N/A Unemployed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Edward Leon Guerrero Salas Sr. Hwa Pok Hong permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2303 Nova Drive Havre De Grace, Maryland 21078 Diana Taylor, Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 11/14/11 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Alyson Taylor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner JANGTENE Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown The law requires 1 Yes 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? this certificate has 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 ☐ Inpatient 2 → ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION Ave HAVre de GRACE, MD21078 BARRUETO, MD 501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 15 Registrar

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only one) 29b. Signature and title of certifier

An THO M

. Date filed (Month, Day, Year) NOV 1 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Examiner

Physician/Medical

Medical Certificate: To Be Completed by

Funeral Director

Completed by

Be

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Physician/ Medical

Examiner

Funeral

Director

State Registrar	5.0.0	, i		-	e of Deat		1ental Hyg	eg. No.	201	3635
1. Decedent's Name (First, Middle							2. Date of Deat Month		Year	3. Time of Death
He Len J	Sorensen			4h Cit	Town, or Locat	tion of Death	November	T	2011 unty of Dea	2:00 AM M
National Luth		mb e r)			ckville				ontgo	
Social Security Number	6. Sex 1 ☐ M 2 🖺 F	7. Age (In yrs. 89	last birthday	Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, July 23		C/	rthplace (State or Foreign ountry) nnesota
Jsual Residence of Decedent							SULY _25	1 1 2 2	2 111	
10a. State 10b. County			ty, Town or							10d. Inside City Limits 1 X Yes 2 □ No
MD Montg	omery	KO	ckvil.	10f. Zir	n Code			Ing Citizer	n of What C	
9701 Viers Dr					20850			USA		yı
1. Marital Status	12. Was Dec	edent Ever in U.	S. 13	3. Was Dece		c Origin? (Spe	ecify Yes or No-		Race - Am	erican Indian,
1 Never Married 2 Mar		2 Ro No		. , ,	city Cuban, Me: 2 No S <i>p</i> ∈		nicari, etc.)	So	Black, Whi ecify:	_{te, etc.} White
3 Widowed 4 Divorced	Year or D	Dates.	160 0-							
(Specify only high	est grade completed		(Gir	cedent's Usu ve kind of wo . DO NOT use	al Occupation ork done during e retired)	most of work	ing	rop. Kind	of Business	s moustry
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7. Father's Name (First, Middle,	Last)						e (First, Middle, N	Maiden Sur	name)	
Norris Nelson	Hi- Mi Dilah		T			Ruth C		01	0/ 1	Zi- Codel
9a. Informant's Name/Relations Kathryn Dahlb		ohter)		-			al Route Number, Lexandria			
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4					adhan male 1	! '	Date		-	
1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (in Mem	other place) 1. Park		1/2011		kfiel	d, WI
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29c. License number

D0051158

ROLKVILLE

29d. Date signed (Month, Day, Year)

MD 20850

NOVENBER

8

2011

State

Registrar DHMH 17 Rev 7/2009 Sark

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23:07р м NOV. 1 2 ay 20 T Physician/ Karen Lee Siebert Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford 125 Breakwater Court Joppa Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 2, 1944 Birthplace (State or Foreign Country) **Funeral** Months Hours 162-36-0815 PA 67 **Director** 1 □ M 2 🕱 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10a State 10b. County Director MD Harford notified Joppa 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code other traumatic event, the Medical Examiner must be Funeral 125 Breakwater Court 21085 USA 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 XNo Specify Specify Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Blue Cross-Blue Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Shield of Maryland 3yrs Executive Assistant and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles W. Walker Minnie A. Neiman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4971 Pale Morning Dunn Road Balto. MD21075 Kelly Nycum /niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Penn-LincolnMemorial 11/19/11 N. Huntingdon PA 4 ☐ Donation 5 ☐ Other (Specify) of Funer | Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Physician/ disease or condition sema Medical resulting in death) **Examiner** ardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine per tension Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical requires that the death certificate be cholesterolemia Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by t Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy nas Yes 2. No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a

To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00043909 Stephanie Linder 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (0V 32. Registi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:30A Physician/ T. Schultz Robert NOVEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death **Examiner** BALTIMORE CENTER TOWSON SAINT JOSEPH MEDICAL Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Days Hours (Month, Day, Year) 216-12-5163 1**X** M 2 □ F **Director** Indiana 90 une 11,1921 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6100 Everall Avenue 21206 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Martins Riveter-Assembler is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ other traumatic Virgil Schultz Lizzie Helm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 703 Squires Road Towson, Md. 21286 Ruth Mettam Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hills 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 11-11-2011 Middle River, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel FuneralHome, Inc 6415 Belair Road Baltimore, Md. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) ACUTE RENAL FAILURE Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Examir Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Year Month g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 XNo 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 2 **X** No 1 🗌 Yes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director; After this letely filled in by the funeral (27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D67248 November 9,2011 MD sted cause of death (Item 23a) (Type, Print)
SON M.D. 7601 OSLER DRIVE TOWSON, MD 21204 GRETCHEN DICKINSON M.D.

DHMH 17 Rev 06-2011

State

Registrar

Day, Year,

NOV 1 5 2011

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State of Mary 1 - State Registrar		epartment of F Certificate of D		Mental Hy	Reg. No.	011	00000
	Discolate	,	Decedent's Name (First, Middle, Last)				2. Date of De	ath C	Vear	3. Time of Death
	Physicia Medic		Edward Michael Thein S	we			· · · · · · · · · · · · · · · · · · ·	er ^{Day} , 2		10:41A M
,	Examin	er	4a. Facility Name (if not institution, give street and number) Suburban Hospital		4b. City, Town, or	Location of Death	1	4c. County		omery
	Funeral			yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Bir	th		place (State or Foreign
	Director		046-36-4975 1 ☒ M 2 ☐ F Usual Residence of Decedent	67 Yrs	1 1 1	Hours Will.	January		Burma	
	and show	٥	Coda: Hesiderice of Beecederic	c. City, Town or	Location		<u></u>			10d. Inside City Limits
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	th the	al D	10e. Street and Number		10f. Zip Code		_	10g. Citizen of		intry?
	ath wi ems 2 r mus	Funeral Director	5920 Wilmett Road 11. Marital Status 12. Was Decedent Ever	in U.S. 1	3. Was Decedent of Hi	20817 spanic Origin? (Sp	pecify Yes or No-		e - Ameri	can Indian,
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ב כ	le 1 an t of He If iten or oth			20b. Place of Dis	sposition (Name of crematory or other place	e) Nove	nber 14,	20c. Location		
	permit. Page 1 Department of Important: If it any injury or o once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Months &	emerym, In	c. 20	11			lary1and
0	Depa Impo any i			01360	Robert A. Pur 7557 Wiscons	in Avenue.	eral Home, Bethesda	/Bethesda Maryland	-Chevy 2081	Chase, Inc. 4-3501
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	cuted nd transit	Examiner	Cause (Disease or injury that initiated events c							
	Attending Physician: The law requires that the death certificate be executed stream. The law requires that the attending physician and expect. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	ial E	resulting in death) Last Due to (or as a con	nsequence of):						
3	cate by physics the last the l	ledical	d							
5	eath certifica attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐		3 Ectopic pregnance	>∨			ate of deli	
200	death the att hed fo	ysici	in the past 12 months? 1 Yes 2 No 9 Unknown		5 Other (specify)			M	onth	Day Year
	that the deaned by the a detached		Part II. Other significant conditions contributing to death but no	ot resulting in th	ne underlying cause giv	ven in Part I.	23e. Did 1	tobacco use con	tribute to	the cause of death?
oldo,	v requires the been signer should be considered.	ed by					1 🗆	Yes 2 🔀 No	3 🗌 Pro	obably 4 🗆 Unknown
5	aw req as bee 2 sho	Completed					24a. Was	psy	prior to c	opsy findings available ompletion of cause of
ב ו	: The I cate h , page						1 X Yes	ormed? 2 No	death?	2 X No
	nysician: The law nis certificate has b I director, page 2 s	To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: 1 Inputient	2 X EB/Outos	26. PI	ace of Death (Che		idence 6 🗆 Oth	ner (Specie	ful.
5	ig Phy ter this neral c		27. Manner of Death 28a. Date of injury	28b. Time	e of 28c. Injur	y at	1	how injury occur		9)
5	tendin leath. or: Aff the fu	Certificate:	2 Accident Investigation		M 1 🗆	Yes 2 No				
2	l or At after c Direct I in by		4 Homicide determined 28e. Place of Injury - building, etc. (S)		street, factory, office		28f. Location (City or To		oer or Huri	al Route Number,
ָנ	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of exami	knowledge, dea	ath occurred at the time	e, date and place,	and due to the c	ause(s) and mar	ner as sta	ated.
	the H thin 24 the Fi mplete	Me	only one) 3 Certifying Nurse Practitioner: To the bes	st of my knowled	dge, death occurred at t	he time, date and	place, and due to	the cause(s) and 29d. Date signs	manner as	s stated.
	₽ № ₽ ⊗		29b. Signature and title of certifier	7)51320		_		10, 2011
	UV		30. Name and address of person who completed cause of death	(Item 23a) (Typ						
	-1		Joshua Shigeru Yamamoto, M.	D. 3301		o Avenue	, Ste.2	50, Wash	ingto	on, D.C. 20016
	Stat Registra		31. Date filed (Month, Day, Year) 32. Jegistrar's S	Signature	La. V. J					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Lolita Solorzano 22 19 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltim If Under 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) 213-88-1229 Director 1 □ M 2**X X** MD 48 Feb. 22 1963 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director with the Maryland notified 28a-f 1XXYes 2 ☐ No MD NA BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f Zip Code ō ms 23a or must be r by Funeral 518 Tunbridge Road 21212 IISA death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 0 1 X Never Married 2 Married 21215-0036 filed within 72 hours after 1 Yes 2X No Specify. Multi "natural" Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "naturury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Care First/BCBS Yrs aim Processor Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Simon Solorzano Addie Mae Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shania L. Brown - Daughter 518 Tunbridge Rd. Balto., MD permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ⊠ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) 11/18/2011 Woodlawn, Woodlawn Signature of Funeral Service Licens 22. Name and Address of Facility March F/H 4300 Wabash Ave. Balto., MD 21215 23a. Part 1. Enter the disease, or complications that shock, or heart allure. List only one cause on e aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (F inal Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IE FEMALE attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) signed by the af Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death?
1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛛 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \(\text{Yes} 2 \(\text{No} \) Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2. the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 18150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ar Baltime ND 21215 et Prestor State

DHMH 17 Rev 06-2011

Registrar

NOV 1

Solorzano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Earl Raymond Temple 33 PM 2 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Square Hospital Center timore 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Day, Year) 1928 1**X** M 2 □ F Months Hours Min 220-24-7431 Mary land **Director** August Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director White Marsh Md Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21162 11133 Bird River Grove Road 13, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Black, White, etc. White Armed Forces?

1 Yes 2 No 1 Never Married 2 XMarried ð Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Black & Decker Heat Treater should be filed with and Mental Hygien 7 is marked other tt 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles W. Temple Anna May Blakley empie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Bird River Grove Road Middle River, Md. 21162 11133 <u>Marie M. Temple</u> Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 11-14-2011 Balto.Md. Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licenses Nottingham, Md. 21236 Mic 9705 Belair Road 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or consequence of): Examiner constitution liet es a differen if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) signed by the aid be detached to Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No ၉ 1 Natient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After 5 Pending 1 X Natural iniury ithin 24 hours after death.

the Funeral Director: At ampleted filled in by the fu 2 No Accident Investigation 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 81 0053694 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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9000 32. Registrar's Signature in Square Drive, Baltimore, MD 21237

11-08293 Cormac Tobin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate Registrar	of Death	, ,	a. No.	
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Madical Exami	iner	COLINAC DANTEL TODIN		November	5, 2011	0845 hrs
		Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital	4b. City, Town, or Location of Death Rockville	1	4c. County of Death Montgomery	
				Data of Birth	(MM/DD/YYYY) 9. Bir	the loss (State of
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	(f) If Under 1 Year If Under 24Hrs Months Days Hours Min	. 1	Foreig	n
Director		216-47-6941 1XM 2F 15	Yrs.	June 2	1, 199 <u>6</u> co	untry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
È						1 Yes 2 X No
Maryland 28a-f show d at once.	ctor	Maryland Montgomery 10e. Street and Number	Potomac 10f. Zip Code	100	g. Citizen of What Cour	ntry?
or 28	Director	10409 Joiners Lane	20854		United St	ataa
0036 within 72 hours after death with the Maryland jeine. ser than "natural", or items 23a or 28s-f sho Medical Examiner must be notified at once.			. Was Decedent of Hispanic Origin? (S	pecify Yes or No-		can Indian, Black,
eath v	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto		White, etc.	
			Yes 2 X No specify:		Specify: Whi	te
ours a	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use ret		16b. Kind of Business/I	ndustry
6 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ig those of working file. DO NOT use fee	iled)		
Withir iene.	μŽ	10	Student		Schoo1	
Hyg doth		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Surname)	
21215-0036 vold be filed within 72 hours after Mental Hygiene. marked other than "natural". c event, the Medical Examiner	o Be	Daniel J. Tobin 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Ellen Es		er City or Town State	Zin Code)
MD 2 d 2 shou lth and h n 27 is n	2		09 Joiners Lane, P			
imore, MD 2 Pages 1 and 2 shoument of Health and Namt: If item 27 is no or other transaction		20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery,		20c. Location - City or	
Baltimore, permit. Pages 1 a Department of He important: If ite		Montgoin	erv i	13,	Bethesda,	Marvland
it. Partimer		4 Donation 5 Other Specify: Cremato	rium, inc. 20	, + +		
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Feath and M Important: If item 27 is no injury or other traumatic.		M01619	Robert A. Pumphrey Fun 7557 Wisconsin Ave	eral Home,	Bethesda-Che	vy Chase, Inc.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Staphylococcus	ter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval
Medical	3 3	Immediate Cause (Final disease a.and Necrotizing Pne		n Myocard	IILIS	Between Onset and Death
čxaminer		or condition resulting in death) Due to (or as a consequence of):	шына			
		Sequentially list conditions, b				
	ig.	if any, leading to immediate cause. Enter Underlying Cause (Clineses in investment intitieted c.				1 1
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u>ا</u>	d.	022 1 0 10)		
be ex urial	Medical	▼ UNPENDED	per me,g923 1-9-12	z sm		
760, ficate bog physic g physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth	2 Tetania arang		23d. Date of delivery	
r 68 certii	Sia	past 12 months? Pregnant at time of death 5	Fetal death 3 Ectopic pregnation (Specify)	aricy	Month [Day Year
Box 687 he death certific the attending I	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (opens))			
o. at the d by t		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		acco use contribute to	
ires that the signed by	d by	Olanzapine Toxicity; Autism		1 Yes	2 No 3 Prot	oably 4 Unknown
ords w requir	ete			24a. Was ar autops		topsy findings available completion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s	Completed			perform	ned? death? ☐ No 1 ✓ Ye	es 2 No
Triffice		25. Was case referred to medical	26.Place of Death (Check			
Vita	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpat	ient 3 DOA Other Nursir	ng Home 5 🔲 R	tesidence 6 Other	
Ing Physi After this funeral dir		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
ion ttendi	읥	1 Accident Investigation (Month, Jay, Year)	1 Yes 2 No			
Division of Vital Records, P.O tal or Attending Physician: The law requires that t is after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	빏	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (State or Town, State		ral Route Number, City
pital cours filled	Certification:	4 Homicide determined (Specify)				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of one) Medical Examiner: On the basis of examination and/or investigation.				
To th withi. To th	Medical	and magner stated.	29c. License number		29d. Date signed (Mo.	
		29b. Signature and title of certifier	O.C.M.E.		November 6, 20	
POME	ļ	/	O.O.IVI.E.		140 VCIIIDEI O, 20	
OL DER	ŀ	30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner	900 W. Baltimore Street Baltin	more, MD 212	223	
ν γ	ate		have			
Reaist		NOV 1 5 2011 /2 A. A	Parke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36366 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NO WEMBER 20 Year MILDRED VANFOSSEN 型型 3:40A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F Hours Min nth, Day, Year) **Director** 73 Yrs Usual Residence of Decedent show. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shou other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 Winchester Ave. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, rmed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William R. Abbott Helen I. Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin W. VanFossen-husband 72 Winchester Ave., Westminster, MD 21157 20a. Method of Disposition permit. Page 1 a
Department of F.
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memoria1 11-17-11 Finksburg, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Fletcher Funeral Home litelin homes 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ neumania Medical resulting in death) ue to (or as a consequence of) Examiner TROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mon Month Day Year Pregnant at time of death 2 No Yes the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 🗐 ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No thin 24 hours after death.

the Funeral Director: Af
mpleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1' 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2

To the I

complet only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-14-2011 D60417 MP

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State Registrar Hemen

31. Date filed (Month, Day, Year,

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Thamas Tohnson

Frederica MD 2170)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b.per fb.g921 11-15-11 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Williams 2011 9:00 P M **Physician** riola /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Care Cold Spring ruture If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month,,Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 M 2 M F Yrs. 10/21 121-20-387 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Battimore Director NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 212 14 USA 4700 Harford Load 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify <u>ک</u> Block 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN Home Home maker d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ٩ UN KNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is many injury or other (Son) 11345 Pylaski Highway # 33 white marsh pate 20 Arthur Williams 21262 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/26/11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carmel Cemetery Baltimore MD 21214 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Jescoh
Razaz
W. North 21. Signature of Puneral Service Licensee FIA. PA Bultimore Avenue MI) 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Feetly re Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the aid 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 ☐ Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 00069 314 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Vo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI Had (Wonth, Day, Jear)

32. Registrars Signature Woods 32. Registrar's Signature State NOV 1 5 2011 Registrar

11-7-11 8:10pm LADYMARIE WISE

			Please '		k Indelible Ink. Ensure		le.
			For State	•	epartment of Health and Certificate of Death	0.0	11 00000
		-	Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. No.	3. Time of Death
3.0	Physicia Medic		Ladymarie		58	Month Day Ye	11 80p M
San all	Examir	er	4a. Facility Name (if not institution, give s Toseph Rich	reet and number) EY Hospic &	4b. City, Town, or Location of Deat Baltimor		Death
	Funeral Director	Г	5. Social Security Number 6. Sex 2.17. 24.8566 1 Usual Residence of Decedent	14.0	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9.	Birthplace (State or Foreign Country) MD.
	Maryland 28a-f show otified at	Director	10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits 1 Yes 2 □ No
	n the Ma a or 288 be notif	al Dire	10e. Street and Number		10f. Zip Code	10g. Citizen of Wha	
	ath wit	Funeral	1622 Gwyni 11. Marital Status		13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	American Indian,
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:	o Rican, etc.) Black, V Specify:	White, etc.
215-0036	2 hour	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Decedent's Usual Occupation Give kind of work done during most of wo	rking 16b. Kind of Busin	ess/Industry
212	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5+)	Ead Dieticion	- Vetere	is tespital
and	should be filed within and Mental Hygiene. Is marked other that aumatic event, the N	To Be	17. Father's Name (First, Middle, Last)	< c	18. Mother's Na	me (First, Middle, Maiden Surname) 4 Preston	
Maryland	should and Me is marl aumati		19a, Informant's Name/Relationship (Typ	e, <i>Print</i>) 19b.	Mailing Address (Street and Number or Ru	ıral Route Number, City or Town, State	, Zip, Code) 20772
2	and 2 s Health tem 27		Kellie Dreher C	niece) los	508 Win Knoll W	Date 20c. Location - Cit	1 baro MD
Baltimore,	Page nent o ant; If Iry or		1/X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		crematory or other place)	Interior Ad 1	LS,MD.
Balt	permit. Page Department Important; I any injury o		21. Sign wire of Funeral Service License	kan	22. Name and Address of Facility	Francis Home, P.	4. MD 21216
	4,		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one		t enter the mode of dying, such as cardiac		Approximate Interval Between
14 E	h, sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	End st	age congestive h	east failure	Onset and Death
	Examiner		ACT I SANGSUM STORY	Due to (or as a consequence of): 1		
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
	executed an and rial-trans		that initiated events resulting in death) Last	Due to (or as a consequence of);		-
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09289	ath certificate be executed attending physician and for use as the burial-transit	an/Me	23b. Was decedent pregnant	Sc. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	2 Fotonio prognancy	23d. Date o	f delivery
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ords	v requir been s	letec	(5) (1)	all allay a	MICOSC	24a. Was an 24b. Wer	e autopsy findings available
of Vital Records,	ician: The law certificate has rector, page 2	Completed by				performed? dear	r to completion of cause of th? Yes 2 No
ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	26. Place of Death (Che		Specify) Hespice
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Divi	ital or A irs after al Directed in b		4 Homicide determined	building, etc. (Specify)		City or Town, State)	
:	to the hospital or Attending Prysician; within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	(Check 2 _ Medical Examine	r: On the basis of examination and/or	eath occurred at the time, date and place, investigation, in my opinion, death occurred edge, death occurred at the time, date and p	at the time, date and place, and due to	the cause(s) and manner stated.
	vithii To th	-	29b. Signature and title of certifier		29c. License number	29d. Date signed (M.	
	100		30. Name and address of person who co	npleted cause of death (Item 23a) (To	(pe, Print)	7 1-	10-11
)		Dr Kauen	COUTINTS BUTH	327 Lindan Av	Batt., MD. 2120	
	Stat Registra		31. Date filed (Month, Day, Year) NOV 1 5 2011	32. Registrar's Signature	Kal		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11 47A M FLROY WILLIAMS NOVEMBER 03 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hark L ake Bult: more Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Min Director 1**X** M 2 □ F 2.14 56 MD show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Baltimore 1 Yes 2 □ No 10e. Street and Number ö 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 4.5.A. 2(2(7 items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 L Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 □ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry المالية عند المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiener is marked other the borer 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Williams 19a. Informant's Name/Relationship (Type, Print) State, Zip Code) Batto, MD 19b. Mailing Address (Street <u>and Number or Rural Route Number, City or Town,</u> Important: If item 27 any injury or other tra Geraldine Anthony (mother-in-las としころ 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) andallstown. 15/2011 uneral Service Licensee 21. Signat Joseph L. Russ truck par 100 222 W. North Avenue 3.16.MD 21216 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEVERE MALNUTRITION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PANCREATITIS CHRONIC Sequentially list conditions, Examiner riany, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). ALCOHOL ABUSE burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be TOW +5 ME Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISORDER SEIZURE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? hours after death. uneral Director: After this certificate I 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NIRMAL KUMAR MI RES DOD NOVEMBER 8TH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD 560 BALTIMORE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36370 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 8:40 M Physician/ MADEL NOLFE ELLEN 160man 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard 10121 Wesleigh Drive Columbia 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday, **Funeral** Hours Sept 11, 1928 Pennsylvania **Director** 189-22-5810 1 M 2X F 83 Usual Residence of Decedent 10d, Inside City Limits 28a-f show 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 X No MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number b rral", or items 23a Examiner must be Funeral USA 10121 Wesleigh Drive 21046 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced White Completed other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, other than Elementary/Secondary (0-12) College (1-4 or 5+) 2 Healthcare Care Giver Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) marked Charles Shultz Olive Connelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 19a. Informant's Name/Relationship (Type, Print) <u>.e</u> 1 and 2 soft Health 10121 Wesleigh Drive Columbia, MD 21046 Don Marlon Wolfe/husband Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 a
Department of It
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 11/15/11 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksvil Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Premodia Physician/ disease or condition resulting in death) Medical Due to (or as a c sequence of **Examiner** Fi blose Dulmose Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Examine Due to (brias a nonsectionne of) nding physician and use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant atten for u Month Day in the past 12 months?

1 Yes 2 No
9 Unknown signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ठे Deservative Denyenta 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed Yes 2 1 Tyes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital 2 No 1 \(\text{Yes} \) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nusse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 22856

State Registrar 11055 Little Rinker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lillie Esther Wilson 11:15p M November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3304 La Dova Way Springdale Prince George's Social Security Number If Under 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Oct 1, Months Hours **Director** 249-46-5557 1 □ M 2 💢 F 82 1929 South Carolina 28a-f shov 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 Yes 2X No MD Prince George's Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3304 La Dova Way 20774 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural". or þ 1 Never Married 2 Married Yes 2X No Yes, Give Specify: African 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 X Widowed 4 Divorced Year or Dates ntal Hygiene. ced other than "natura c event, the Medical E American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Teacher Education Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theron Edward Fulton injury or other traumatic Esther Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Wilson/son 4507 Holmehurst Way Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Tremation 3 Removal from State Final Journey Crematory 11/15/11 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Lice Coing Home Cremation Service P.O. Box 784 L. Heckrotte, P.A. Clarksville, of dvind. such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 100 3 ☐ Probably 4 ☐ Unknown aune Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗆 No Yes 2 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 24 hours after death. Funeral Director: After t Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 0

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 1:55PM Day Physician/ CHARLES EDWARD WINSTON 11-12-20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 230-60-1861 Director 1 **X**M 2 □ F 65 Yrs 06-10-1946 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MDBALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? HALSTEAD ROAD 1320 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) MARRIOTT Sous CHEF 12 Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIE MARGARET WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALENCIA WINTERBERRY CT. YORK, PA. 17408 VAUGHN (DAUGHTER) 1365 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 122/2011 BATTIMORE, MD GARRISON FOREST ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCKS 21. Signature of Funeral Service Licensee ROAD. BALTO, MO. 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of). Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): and burial-trar resulting in death) Last Due to (or as a consequence of): physician s the burial requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed this certificate has 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 **N**O ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the ! Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier MD D71046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI GFOI NCHARLES KUMAR RALTIMORE 4105 31. Date filed (Month, Day, Year) State

Registrar

NOV 1 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death Physician/ œ leen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Essex Riverview Nursing Home 8. Date of Birth (Month, Day, Year) 12–16–1923 9. Birthplace (State or Foreign If Unde If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours Min 217-14-5396 Director Pennsylvania 1 🗆 M 2 😿 F 84 show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 28a-f 1 ☐ Yes 2 X No White Marsh Balto. Md ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA Funeral 21162 11307 Beach Road death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc o þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify. White "natural", Completed 3 Widowed 4 Divorced Specify. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Daily Thomas Seymore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is White Marsh, Md. 21162 Son 11307 Beach Rd. Thomas J. Westerfield 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Department of Important: If any injury or once. injury or 11-10-2011 Glen Burnie, Md. 4 Donation 5 Other (Specify) Atlantic Crematory Schimunek FuneralHome, e of Funeral Service License 22. Name and Address of Facility nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the dearh certificate be executed and -trar that initiated events Due to (or as a consequence of): resulting in death) Last a tending physician Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year signed by the a 2 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perforn death? certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Accider 5 Pending injury 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o

State Registrar mpleted cause of death (Item 23a) (Typ

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene											
			State Registrar		Cer	tificate of L	Death	- T	Reg. No. 20 363/4			
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greas.	Medic		Paul 4a. Facility Name (if not institution, give street and numb	W.	Wang	1h City Town or	r Location of Deat	November	11, 201 4c. County of De			
	Examir	ier	9525 Newbridge Driv	*		4b. Gity, Town, or	Potomac			gomery		
	Funeral			. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs		9. E	Birthplace (State or Foreign		
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	od at] _	Usual Residence of Decedent 10a. State 10b. County	65	ty, Town or Lo	ration		May 6, 1	946	China 10d. Inside City Limits		
	arylar a-fsł fied	Director		100.01	ty, form of Loc		- h a			1 Yes 2 X No		
	or 28	Ë	Maryland Montgomery 10e. Street and Number			10f. Zip Code	otomac_	100	. Citizen of What	Country?		
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	9525 Newbridge Driv	P		2	20854		United	States		
	items er mi	E E	11. Marital Status 12. Was Deced	ent Ever in U.	S. 13. V	Vas Decedent of H Yes, specify Cuba		pecify Yes or No-	14. Race - Ar	nerican Indian,		
36	", or i	Ş	1 Never Married 2 X Married 1 Yes	2 X No		Yes 2 X No		to rican, etc./	Black, Wh	nite, etc.		
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	Illed vall Hyg	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Mai				
Maryland	e 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	은	Unknown					Unkno	wn			
Aar	shou and is m		19a. Informant's Name/Relationship (Type, Print)		1	-		ural Route Number, Ci				
	and 2 s Health tem 27		Shumei C. Wang/ Wife 20a. Method of Disposition	Tag: r			ge Drive,	, Potomac,				
Baltimore,	e		1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from S	itate 200. F	race of Dispos remetery, crem	sition (Name of natory or other place Dinery	e) Nove	mber 17,	c. Location - City			
Ę	permit. Page Department Important: I any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		Cremat	torium, I	nc. 2			Maryland		
Ba	permit. Departr Importa any inju		> grh J. Panne	- MO1:	360 Ro	bert A. Pur 57 Wiscons	mphrey Fun in Avenue.	erai Home/Be Bethesda, Ma	thesda-Che arvland 208	vy Chase, Inc. 314-3501		
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on eac	used the deat						Approximate		
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Вох	ss that the death certific, igned by the attending p be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown	ant at time of o wn	death 5	Other (specify)			Month	Day Year		
P.O.	Physician: The law requires that the this cartificate has been signed by the rail director, page 2 should be detach		Part II. Other significant conditions contributing to dea	ath but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	co use contribute	to the cause of death?		
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ord	v require been signal	olete						24a. Was an	24b. Were	autopsy findings available		
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Division of Vital Records,	lor A after Direction by			, etc. (Specify		et, factory, office		City or Town, S		Rural Route Number,		
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Mec	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner:	of examination the best of r	n and/or investi ny knowledge,	gation, in my opinic death occurred at t	on, death occurred he time, date and p	at the time, date and polace, and due to the c	lace, and due to th ause(s) and manne	e cause(s) and manner stated. r as stated.		
	To To Con		29b. Signature and title of certifier Matthia Mal	(1		29c. License			. Date signed (Mo			
	es /						66030	4 1	-11-	7.011		
	180		30. Name and address of person who completed cause				Raltimor	a Marula	d 21231			
	Stat	e	Matthias Holdhoff, M.D. 31. Date filed (Month, Day, Year) 32	401 NC	ture		DartrillOL	e, maryiai	id 21231			
	Registra				8. Soa	Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 36375 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Constance Marie Wetzel 3:15P November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Elizabeth's Nursing Home Baltimore None Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 213 30 4086 Director 1 □ M 2 🔀 F 78 12-25-1932 Maryland show items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 XNo MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 2522 McKenzie Road 21042 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) Consultant Clinique Cosmetics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Robert Stamp Myrtle Scotten traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Mark D. Wetzel/Son <u>2522 McKenzie Road Ellicott City, MD 21042</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11-15-2011 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicin disease or condition resulting in death) Medical s a consequence of **Examiner** Sequentially list conditions, if any hading to immediate cause. Enter Underlying ner Exami attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
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To the Funeral Director: After to completely filled in by the funer. 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 1 🗆 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month. Dav. Year)

Registrar

DHMH 17 Rev 06-2011

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Nonth, Day, Year)

Nov. 15, 2011

Yarosh evich

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Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from S	tate '	cemetery, cren	natory or ot	ther plac						•		and
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36377 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 12 Physician/ ^{Day} 2011 Year Margaret Louise Zepp 11:59PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Lookabout Manor Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) 2-9-1923 1 □ M 2 🕱 F 219-14-9945 87 Yrs Director MĎ Usual Residence of Decedent show 10a, State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director Carroll Westminster 28a-f MD 1 Yes 2X No 10e Street and Number ö 10f. Zip Code 10a. Citizen of What Country? ms 23a or must be n Funeral USA 1510 Stone Rd. 21158 items death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 3altimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Carrie Lookingbill James M. Glacken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 247 Stafford Dr., Hanover, PA 17331 Linda M. Zinn-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-16-11 Shipley, MD 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 21157 Monas Main St., Westminster, MD 254 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) , Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 has page 2 • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate! 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Tes 2 1 No 0 1 Inpatient 2 ER/Outpatient 3 DOA funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 6 🗌 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🖟 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 3 only one) 29b. Sign re and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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1	Medic	0	ta. Facility Name (if not institution, give s	treet and number)		4b. City,	Town, or L	ocation of Death		4c. County		
4	189	or ·	218 MARKET STREE			DI	ENTON				OLINE	
2	Funeral Director		5 Social Security Number 6, Se.	7 Age (In	yrs. last birthday 9-58 Yrs.) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 11/12/	952	9. Birthplace (State or For MARYLAND	reign
	*		Usual Residence of Decedent	10	c. City, Town or L	coation					10d. Inside City Li	mits
	/land f sho ed at	to	10a. State 10b. County								1 💢 Yes 2	⊒ No
	Mar 28a- otifi	Director	MD CAROLIN	E	DENT	10f. Zip	Code			10a. Citizen of	What Country?	
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	r iter iner		11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, spec	cify Cuban	, Mexican, Puerto	Rican, etc.)		ack, White, etc.	
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Maryland 21215-0036	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	15. Decedent's Ed	ucation	16a. Dec	edent's Usu	al Occupat	tion uring most of work	ina	16b. Kind of I	Business Industry	
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<u>8</u>	Id be Ment arke	ျ	JOHN WILLIAM AI					nd Number or Run		r City or Town	State Zin Code)	
<u>a</u>	shou and is m		19a. Informant's Name/Relationship (Ty JOHN W. ADAMS, II		19b. Ma	iling Addres RATTC	s (Street ar NECK	PI.ANTAT	TON. ST	EVENSU	LLE, MD 2166	6
2	und 2 lealth im 27 her t		20a. Method of Disposition		20b. Place of Dis			-	Date Date		- City or Town, State	
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my righty or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	49/	^ -]	FELLOW	S, HE	LFENBEIN	1 & NEWN	AM FUNI	ERAL HOME, P.	Α.
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Ö X	endir r use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	Fetal death	3 Ectopio		y			Date of delivery Month Day Yea	ar
Box	death	sici	1 Yes 2 No	4 ☐ Pregnant at t g ☐ Unknown	ime of death	5 Other (specity)					
	t the	P.	Part II. Other significant conditions of	ontributing to death but	not resulting in the	ne underlying	g cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to the cause of dea	th?
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Siol	ttendir death. ctor: Af y the fu	Certificate:	3 Suicide 6 Could not I	28e. Place of Injury	y - At home, farm	, street, facto	ory, office		28f. Location	(Street and Nu.	mber or Rural Route Number	r,
Division	after A Direct			building, etc.	(Specify)							
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. * To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical		rsician: To the best of m								ner stated
	n 24 n 24 ne Fu	Med	(Check 2 Medical Examonly one) 3 Certifying Nu	se Practioner: To the b	est of my knowled	ige, death oc	curred at tr	le lime, date and p	lace, and due to	110 0====(+)		
	To the within 2 To the comple		29b. Signature and title of certifier			2	9c. Licens		09		gned (Month, Day, Year)	
	Ens		James p		10		UO	27.200	0 (10/	/	
	עון .		38 Name and address of person who	completed cause of de	ath (Item 23a) (Ty	pe, Print)	, 40	n sal	TAN	MD =	1679	
			21 Date filed (Month Day Vear)	30 Registrar	's Signature	has	<u>~/V</u>	DEN	000	,	7 0 0 1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month arole 5:45 am Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis 6. Sex 1 ☐ M 2 💢 F 9. Birthplace (State or Foreign Country) MA Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 4/12/1934 Hours Director 045-24-9899 Usual Residence of Decedent 28a-f show 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MD Anne Arundel Annapolis ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral within 72 hours after death with 1246 Stillwoods Way USA 21403 items ; should be moved and Mental Hygiene.
I is marked other than "natural", or item Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Historian Education traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Prindle Isabel Charbonneau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau Antonio Ancona / Husband 1246 Stillwoods Way, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 3 Other (Specify) Kalas Crematory 10/28/2011 Edgewater, MD 21. Signate 22. Name and Address of Facility George P. Kalas Funeral Home Service Licenses 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part T Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, onset and reath Immediate Cause (Final Ph_sician/ a SToma -4001 disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending physical at the second IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a Id be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 page death? After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff
d in by the fur Accident Investigation M 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R 118703 who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

200

State

30 Name and address of person

31. Date filed (Month, Day, Year)

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OCT 31

-Taylor

32. Registrar's Signature

Defense HWY, ANNAPOLIS, MO 21401

11-08159	
Octavio Azcuy	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	,	-	30. Name and address of person	who completed caus	e of death (Item	23a)								
State 31. Date filed (Month, Day Year) 32: Registra's Stignaure						,	/. Baltimo	ore Str	eet, Ba	ltimore	, MD 2122	3		
COMMODULE INTERVIEW AND A STREET	Sta	ate	31. Date filed (Month, Day Year)	32-Re	grstr 's Signal	ire del								

PA

Year

2 No

To the Hospital or Attending Physician: within 24 hours after death.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 11803 Mason St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined found in dwelling (Specify) Beltsville,Md. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) hd manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. November 6, 2011

30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD.

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 4a. Facility Name (if not institution, give sheet and nu NOVEMBER 20 II 06:08 AM Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL BURNIE HRUNDEL GLEN ANNE 9. Birthplace (State or Foreign Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, 1 . M 2 F Months Hours Min **Director** Yrs. Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified i 1 ☐ Yes 2 ☑ No 10e. Street and Number 10g. Citizen of What Country? Funeral GLENEAGLE death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced りんけん 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry AUBURGER, LINDA Elementary/Seconday (0-12) 2 permit. Page 1 and 2 should be filed wii Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ ハろい 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PASADENA, MD. Z1122 8028 ABREY CT. UNIT L. KRISTINA WOOD, DAURHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ODENTON, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Gastroe Medical Examiner Sequentially list conditions. Examine sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month Day Year Pregnant at time of death page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No 1 Yes 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred (Month, Day, Year) iniury 5 Pending 2 🗌 No Accident Investigation ו 24 hours after deatl e **Funeral Director**; completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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NOV

30

32. Registra s Signatu

Registrar

State

31. Date filed (Month, Day, Year) 0CT 3 1 2011

2. Registrar's Signature

Please Type or Print in Black Indeligie Ink Ensure All Panies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lois Alberta BAKER Physician/ October 30°, 2011ear 15 al Medical 4b. City, Town, or Location of Death Big Pool 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Washington 9811 National Pike If Under 1 Year If Under 24 Hrs.

11 Under 24 Hrs.

12 Under 24 Hrs.

13 Under 24 Hrs.

14 Under 24 Hrs.

15 Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Sept. 16,1947 Maryland 214-54-2413 64 Director be filed within (2 11-2-11-2) fental Hygiene.

arked other than "natural", or items 23a or 28a-1 snow.

Aric event, the Medical Examiner must be notified at Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Clear Spring Maryland Washington 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 21722 14425 Hicksville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 white 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 state government supply supervisor traumatic event, Be permit. Page 1 and 2 should be flee
Department of Heath and Mental Hy
Important: If item 27 is marked oft
any injury or other from 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Irene Shafer ျှ Albert Eugene Mellott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie Baker - son 9811 National Pike, Big Pool, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Cedar Lawn Memorial 1 Burial 2 Cremation 3 Removal from State November 2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee Minnich Funeral Home 22. Name and Address of Facility white Ran 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ DO ST ye DU disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Quality (or as a nonsequence of): if any, leading to immedicause, Enter Underlying Examin attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be 49, 106 4 26 #290 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year detached for Month Day 5 Other (specify) Pregnant at time of death the signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an performa: certificate 25. Was case referred to medical To Be 26. Place of Death (Check only one) Son's examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Inpatient 2 ER/Outpatient 3 DOA 5 Hesidence 6 M Other (Specify) residence hours after death. uneral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 1 Tes Accident filled in by the I Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 3 November 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown MD 21740 TW-10 31. Date filed (Month istrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Brown Physician/ 315 CM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day Apr 16 g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday, **Funeral** Months ^{Year} 1918 Maryland 216-18-5184 **Director** 1 □ M 2**X** F 93 Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21401 42 Murray Ave death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. per nit. Page 1 and 2 should be filed within 72 hours after c De; artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinance. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Yes Give Completed 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) None Housewife Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Edith Wallace James Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21401 Charlotte Brown (Daughter) 42 Murray Ave 20a. Method of Disposition 20c. Location - City or Town, State 20b. Pacco Dippastice (Name of cemetery, erematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 11 - 4 - 11Annapolis, Md. Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) M Manne a Race Seof Recility Sons Mortuary, P.A. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 12, Trees 23a. Part 1. Enter th disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause one each in e. Approximate Interval Between Ons and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner nemi Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ≥ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy perform death? 1 Yes 2 No this certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury Natural 5 Pending Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined To the Hospital Medical 🛨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tricia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 3 1 2011

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36386 State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 25 2011 2:40 PM Lenue Bethea Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 4405 Summit Place Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, . Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 251-76-8071 **Director** 1 **X** M 2 □ F Sept 15 1944 Carolina 67 Yrs. Usual Residence of Decedent 28a-f show Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No MarylandPrince George's Ft. Washington 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral 4405 Summit Place 20744 USA items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. o by 1 Never Married 2X Married 72 hours after Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", **Black** 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Prince George's Co. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Board of Education 6th Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ Lumis Richardson Gertrude Bowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 sh Department of Health a Important: If Item 27 is Rosemary Bethea(Wife) 4405 Summit Place Ft. Washington, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 5 1 X Burial 2 Cremation 3 Removal from State Resurrection Cem 10-29-11 injury 0 Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname aRease of Beilit Sons Mortuary, P.A. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death Carcinoma with Physician/ Jastuic o month disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine due to (or se a consequence of if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Director; After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD 25 646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VARNUM Street N.E #117; Wash DC, 20017 MEWIN GERALD, MID

Registrar

State

31. Date filed (Month, Day, Year)

OCT 3 1 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Physician/ 201 Medical County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4b. City, If Under 24 Hrs. g. Birt 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 1 **X**M 2 □ F Months Days Hours Min. Director 28a-f show 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location 72 hours after death with the Maryland must be notified at Director 1 Yes 2 ☐ No 10e Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 20711 LISH items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status the Medical Examiner Black, White, etc. 6 þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Private aintenance 916 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Robert Reimer Lothian Md 25111 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility any in Nd Zozzy hmore complications that caused the death. Do not enter the mode of dying, 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ oars disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of; the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Yea 5 Other (specify) Pregnant at time of death been signed by the s should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 1 Yes 2 No 3 Probably 4 Unknown Completed silure to 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has autopsy 45phagia certificate 1 Yes 2 No Yes 2 Division of Vital 25. Was ca e referred medical funeral director, 26 Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After injury 5 Pending Accident Natural work? 2 🗆 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolus Rd # 232 Glenn Dale Ald 20769

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificate of Death Reg. No.												
Physicia		n/ 1. Decedent's Name (First, Middle, Last)									3. Time of Death 0924 hrs		
ledical Exami	ner	Caleb Frank B	allard							October 2			
		ta. Facility Name (if not institution, given	ve street and number)			•	vn, or Lo	ocation of	Death		l.	ty of Deat	
		6954 Scotch Drive				.aurel							
Funeral		5. Social Security Number 6. S	ex 7. Age (In yi	s. last birthday)		Months	1 Year Days	If Under Hours				Forei	
Director		578-60-0227 ₁ ×	M 2 F 65	,	Yrs.	MOUNT	Days	1,0013	771111.	July 4	, 1946	Co	ountry) DC
	ŀ	Usual Residence of Decedent											10d Incide City Limits
Au A	1	10a. State 10b. County		City, Town or Lo	cation								10d. Inside City Limits
aryland Sa-f show at once.	٦	MD Prince	George's La	ırel									
aryla 8a-f	헗	10e. Street and Number			10	Of. Zip Co				1	l0g. Citizen of		
he M	Director	6934 Scotch Drive	2			2070	07				United	Sta	tes
ath with the Maryland items 23a or 28a-f sbo ist be notified at once.		11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was D	ecedent	of Hispa	anic Origi	n? (Spec	cify Yes or No		ace - Ame	rican Indian, Black,
item	Funeral	1 Never Married 2 Marrie	d Armed Forces?		if Yes,	specify (Juban, r	viexican, i	Puerto R	ican, etc.)		D 1	1-
her d		3 Widowed 4 Divorce	d If Yes, Give Year or Dates:	1[Ye	s 2 _X	No	specify:			Speci	fy: DI	ack
urs a smir	d b	15. Decedent's Education (Specify of	only highest grade completed	1) 16a. Dece				n (Give ki OO NOT u			16b. Kind of	Business	/Industry
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D36 Ithin ne.	립	12th		Stat	ion	Man	ager	:			Priva		
5-0 ed wi fygie other	3	17. Father's Name (First, Middle, Las	t)	•			18	3. Mother's	Name (F	First, Middle,	Maiden Surna	ime)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than		Caleb Handy Balla									Jolly		
Ould d Me	P	19a. Informant's Name/Relationship (- 1							mber, City or		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Mena Young-Harri								., Temp	ole Hil	LS,	MD 20748 or Town, State
Fites		20a. Method of Disposition 1 X Burial 2 Cremation 3		Ob. Place of Dis crematory of			of ceme						
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specif	ΙΛ.	rlingto	n Na	atio	na1		12/7	7/2011	Arlin	igton	, VA
artme orta	ı	21. Signature of Funeral Service						of Facility	Pop	e Fun	eral Ho	mes,	P.A.
E P P P		Kest a. Au	we MOIOFS	- 1	5538	8 Ma:	r1bc	ro P	ike,	Fores	stville	,MD	
Physician		23a. Párt I. Enter the disease, or com	plications that caused the de	ath. Do not ent	er the i	mode of	dying, s	uch as ca	rdiac or r	respiratory ar	rest, shock, or	r heart	Approximate Interval Between Onset and
Medical		failure. List only one cause on a	a. Contact gunshot wo	und of chest	t								Death
ixaminer		or condition resulting in death)	Due to (or as a consequen-										
		Sequentially list conditions,)										
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	E	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):									
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3760, ificate be executed g physician and s the burial - transit	n/Medical	UNPENDED	AMENDED	-									
8760, ificate be ug physici	P	IF FEMALE:	23c. If yes, outcome of	oregnancy			-	-			23d. Dat	e of delive	ery
1970 Tifica Ing pl	Ž	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal	death	3	Ectopic	pregnan	су	Mont	th	Day Year
Box 68 le death certi the attendin	ici	1 Yes 2 No 9 Unknow	4 Pregnant at time of	of death 5	Other	r (Specif	ý) _				1/2		
Box 687 he death certific the attending perfection of the perfecti	Physicia	Part II. Other significant conditions	9 Oliviowii	at resulting in t	ho und	lorlying c	auco ais	ven in Par	+ I	23e Did	tobacco use c	ontribute t	to the cause of death?
P.O.	by P	Part II. Other significant conditions	contributing to death but i	tot resulting in t	ne una	ienying c	ause gr	verriir ai					obably 4 🗸 Unknown
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Division of Vital Records, tal or Attending Physician: The law requir is after death. In Director. After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be as the funeral director.		25. Was case referred to medical				26	.Place	of Death (Check or	nly one)			
/ita rsicia nis cer direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpat	tient 3	3 🔲 DO	A C	Other4			Residence		ner: Scene
of \ng Phy	5	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time		ıry 28	c. Injury	at Work		28d. Describe Subject sh	how injury or	curred	
he fu	tior	1 Natural 5 Pending	0-4.04 2044	FOUND: 0920 hrs		_	1 Y	es 2 🗸	No C	oubject 311	Ot SCII		
ision Atte	E2	2 Accident Investigate 3 Suicide 6 Could no	28e Place of Injury -			factory, o	office bu	ilding, etc	a. 2	28f. Location	(Street and N	umber or f	Rural Route Number, City
ital o	Certification:	4 Homicide determin		Family Hom	е				6	954 Scotch	State) Drive, Laur	el, MD	
Hospi 4 hou Fune ely fil		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, death o	ccurre	d at the ti	ime, dat	e and pla	ce, and o	due to the ca	use(s) and ma	nner as st	ated.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examin	er:On the basis of examinat and manner stated.	ion and/or inves	tigation	n, in my o	opinion,	death occ	curred at	the time, dat	e and place, a	and due to	the cause(s)
To wit	Me	29b. Signature and title of certifier	and manner stated.			29c.	License	number			29d. Date	signed (A	Month, Day, Year)
		11/1/11	11-01+1				O.C.N	Λ.E.	004	AΕ	Octobe	r 22, 20	11
	- 3	3 Name and address of person wh		(Mem 23a)									
R		Theodore M. King, Jr., M			r 90	00 W. E	Baltim	ore Str	eet, Ba	altimore, N	MD 21223		
	tate		32. Registrar's Si	geature.									
S Regis		31. Date filed (Month, Day Year) NOV 0 2 2011	Ceans S.	back	_								
	_		/										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🛭 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:25 P M GLORIA T. BOOZER 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CENTER PRINCE CLINTON GEORGE'S . Social Security Number If Under Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) 578-50-6366 74 **Director** 02/19/1937 DC Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1x Yes 2 No MD Charles Waldorf ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20601 United States 1303 Harwich Drive permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: "natural", 3 Divorced 4 Divorced Black Completed Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) 12th College (1-4 or 5+) Mental Hygiene. Accounting Technician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve 2 Carlos Austin Roberson Marie Young 19a. Informant's Name/Relationship (Type, Print) fitem 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Vicki Boozer/Daughter</u> 1303 Harwich Drive, Waldorf, Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Maryland Veterans 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) at Cheltenham 11/7/2011 Cheltenham, Maryland 21. Sign vure f Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_{sician}/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and the burial-tran Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 -No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be director, page 2 s has performed' 2 ANO 1 Yes ours after death.

eral Director: After this certific, filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 ANO Other: 1 🗌 Yes ဂ္ 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 A Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral L Hospital Medical 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DO037066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7. O Paig Leagu, no 61880 cm HILLE #701 0 xon HIL MD 20745 31. Date filed (Month, Day Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2, Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 5:23PM John W. Bredbenner, Sr. 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Doctors Community Hospital Lanham 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 03/06/1921 Pennsylvania 579-16-9749 90 Director Usual Residence of Decedent or items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 XYes 2 No Maryland Prince Georges Lanham 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 20706 USA 7405 Wilhelm Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▲ Yes 2 □ No If Yes, Give WWII Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 🕅 Widowed 4 🗆 Divorced or other traumatic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N.S.A. Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o Emma Gould Benjamin Bredbenner 19a. Informant's Name/Relationship (Type, Print) John W. Bredbenner, Jr. (Son) 19b. Mailing Address (Street and Number or Rural Royte Number. City or Town, State, Zip Code) 330 Highland Dr. Edgewater, MD 21037 f Health item 27 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 4 Donation → □ Other (Specify) 11/2/2011 Beltsville, Maryland Chesapeake Crematory ! Signature of Feneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. P. 1. Enter the disease, or connections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. He may one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ STROKE EMBOLIC Medical Due to (or as a consequence of): **Examiner** ATRIAL FIBRILLATI Sequentially list conditions, if any, leading to immediate cause. Little Ordenying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 2 - No Yes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury w<u>ork</u> 1 Natural 5 \square Pending 1 Yes 2 | No M 2 Accident Investigation Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number

Registrar

State

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SEISOTDO

ND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASUR.

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 26, 2011 William 1910 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month Day, Ye Months Days Hours Director 73 577-46-6348 DC Usual Residence of Decedent or 28a-f show notified at 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a f show traumatic event, the Medical Examiner must be notifited at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖾 Yes 2 🗌 No Prince George's Maryland Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5023 Emo Street NE 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 American 1 Yes 2 No Specify. African 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Bondman Agent Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Brown Sr. Fannie May Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 i Thomas Brown - Brother 4423 E Street SE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date Page 1 1 🗌 Burial 2 🔀 Cremation 3 🗀 Removal from State permit, Page Department of Important; If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. the 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac Approximate shock, or heart failure. List only one cause, on Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3

Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of D th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 2 No 3-☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Funeral Directory 29a. Certifier fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume Fractioner to the cast of my his wild go could occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date sign 29c. License number ed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20785 CATEVENIS 3001 HOSPITAL DR. State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - State Registrar	Cert	tificate of Death	Reg. I	No.
Ē.,	Physicia Medic	al		UDIE		2. Date of Death Month	
	Examir	ier	4a. Facility Name (if not institution, give street and number of the surface of t	COL CENTU	4b. City, Town, or Location of Death		4c. County of Death **MICOMICO**
# .	Funeral Director		5. Social Security Number 6. Sex 1 I M 2 SF Usual Residence of Decedent	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) PA
	yland -f shov ed at	ctor	10a. State 10b. County WICOMICO	10c. City, Town or Loc			10d. Inside City Limits 1 I Yes 2 □ No
	or 28a	Director	MD Wicomico	SAUSB	10f. Zip Code	100.0	Citizen of What Country?
	s 23a ust be	Funeral	1018 FAIRGROUND D	SIVE	21801		USA
336	s filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceded Armed Force 1 Yes 2 If Yes, Give	es? If	As Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
215-0036	2 hours "natur dical l	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupation ind of work done during most of work	dina 16b.	Kind of Business/Industry
2121	ithin 72 ene. r than the Me	Completed	Elementary (Secondary (0-12) College (1-4	or 5+) life. DO	ONOT use retired) OMEMAKER		IN HOME
	be filed within ental Hygiene. ked other tha ic event, the I	Be	17. Father's Name (First, Middle, Last)	1 1 1	18. Mother's Nam	ne (First, Middle, Malde	
Maryland	should be filed within 7; and Mental Hygiene. is marked other than raumatic event, the Me	ပ္	HOUS BUNDIE	2000 to 3		SCRIE 3	SESTER
	1 and 2 should be f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) (SINANCY BAUM GARTNER		g Address (Street and Number or Rur PeachTree De 14	al Route Number, City	
ore,	O 4- 1-		20a. Method of Disposition 1	20b. Place of Dispos			Location - City or Town, State
Baltimore,	E Pac trant tant jury		4 Donation 5 Other (Specify)	SPUBBURU CI	remotery 10-24	9-11 BA	ISBURYMD
Ba	permit. Departr Imports any inje		21. Signature of Funeral Service Vicensee	m	Name and Add s of Facility Silk Fineral HCMF	PO BOX 61 1	SIKILLE, MD 8/8/4
	Physician/		23a. Part / Enter the disease, or complications that caushock, or heart failure. List only one cause on each Immediate Cause (Final	line.			Approximate Interval Between Onset and Death
	Medical		resulting in death) a. Due to (or	as a consequence of):	lengencome	of until	
- Jan.	Examiner	ē	Sequentially list conditions, b.				1 month
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	as a consequence of):			
	e execuian an		that initiated events c. resulting in death) Last Due to (or	as a consequence of):			
8760	tificate be executed ng physician and as the burial-transi	Medical	d				
Box 6	death cer	Physician/M		th 2 Fetal death 3 Interest at time of death 5 Interest Interest 1	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	quires that tl en signed by ould be deta	ρ	Part II. Other significant conditions contributing to dea	th but not resulting in the un	derlying cause given in Part I.		o use contribute to the cause of death?
Division of Vital Records,	The law ate has page 2	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
/ital	rsician s certifi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 logical hospital: 1 logical	patient 2 ER/Outpatient	26. Place of Death (Chec	k only one) ome 5 Residence	6 Other (Specify)
on of \	ath. r: After this re funeral di		27. Manner of Death 1		28c. Injury at work? M 1 Yes 2 No	28d. Describe how inj	
Divisi	To the Hospital or Attending Physician: with 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.			Injury - At home, farm, streetc. (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physician: To the bes (Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner: To	of examination and/or investig	gation, in my opinion, death occurred a	t the time, date and pla	ce, and due to the cause(s) and manner stated.
	To the comp		29b. Signature and title of certifier		29c. License number	T	Date signed (Month, Day, Year)
	P		Will Hym	Internist	H71890		10/26/2011
-	3 NI		30. Name and address of person who completed cause of the Name and DO 166		int) coke Dr., Salish	oweir MD	21804
	Stat Registra	e		strar's Signature	uke	7	•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a,c,d,pt. II g926 4-9-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NMN Eric Bittner 9:22 November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F 03 20 J Waynesboro, PA **Director** 218-50-3022 1946 65 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at 10c, City, Town or Location Director 1 Yes 2X No Franklin PA Mercersburg 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? Funeral 23a 17236 11120 Shimpstown Rd. US items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 X Yes
If Yes, Give ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white 3 Widowed 4 Divorced Specify: "natural", Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) tool rental company should be filed with and Mental Hygien 7 is marked other t owner/operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ R. Johnston Bittner Catherine Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau 13775 Hollowell Church Rd. Waynesboro, PA 17268 Lori Miller /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Cumberland Valley Crem. 11/8/2011 Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Miller-Bowersox Funeral Home 17225 521 S. Washington St. Greencastle, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset **a Xi S**eath Toxic Encephalopathy Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Days Examiner Sequentially list conditions, if any, leading to immediate Examine ence of years Diabetes Mellitus Cause (Disease or linjury executed that initiated events resulting in death) Last and burial-trar equence of Days Septicemia physician s the burial Physician/Medical that the death certificate be Box 68760 nding parse as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the orbierlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation, Multiinfarct Dementia, page 2 autopsy perform Cerebrovascular Accident, Renal Failure 2 🗌 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral c 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending thours after death.

uneral Director: Afted filled in by the fur 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral Completed filled Hospital Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, 1ac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) autickur

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month. Day, Year

			For State	State of Maryla	nd / Depa		Health and N	Mental Hygie	ene	e. 3630
ľ	Physicia	an/	Registrar 1. Decedent's Name (First, Middle, Last	A 0			Jean T	Date of Death Month	Day Yes	
3	Medi Examin		4a. Facility Name (if not institution, gives		Pater		r Location of Death	10 2	4c County of D	
2	Funeral Director	Г	5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9.	Birthplace (State or Foreign Country)
		o.	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Loc	ation		3-4-1	932	10d. Inside City Limits
	the Maryl or 28a-f e notified	Direct	VA Accom	ack Cl	nincot	eague 10f. Zip Code	Island		g. Citizen of What	1 MaCYes 2 ☐ No Country?
	eath with ems 23a r must b	Funeral Director	3561 Ridge	Rd. 12. Was Decedent Ever in U	J.S. 13. W		3336 ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian,
9800	rs after de Iral", or it Examine	ρ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 1950 -	1	Yes, specify Cuba		Rican, etc.)	Black, W	White, etc.
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give k	NOT use retired)	during most of worki	ing 16	Sb. Kind of Busine	
nd 21	filed with al Hygier d other t	Be	17. Father's Name (First, Middle, Last)			<i>Jeliver</i>	18. Mother's Name	e (First, Middle, Mai		Street Supply
ıryla	ould be nd Ment marker matic e	2	Clarence 19a. Informant's Name/Relationship (Ty)	J. Brasi		a Address /Stract	Florence and Number or Rura		Thorn	
, Ma	and 2 sho Health ar em 27 is ther trau		Faith Nichols	on I Daughter	P.O.	Box 21		ncoteaguz	-	2333L
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Dispos cemetery, crem	atory or other plac	ery 10-2		hincole	or Town, State
Balti	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service License		22.	Name and Addres	ss of Facility	Chincotce		አ333 ር
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final							Approximate Interval Between Onset and Death
	Ph, sician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as a conse	quence of):					
	ed sit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Une fo (or as a nonse	dienor og.					is.
0	be executed sician and burial-transit	<u>a</u>	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
68760	certificate I anding phys use as the	/Medi	IF FEMALE:	d			7377			
Box	death	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnand Other (specify)	cy		23d. Date of Month	delivery Day Year
ls, P.O.	To the Hospital or Attending Physician: The law requires that the within E4 hours after death. To the Funeral Director. After this certificate has been signed by the Completely filled in by the funeral director, page 2 should be detach.	ed by PI	Part II. Other significant conditions col	ntributing to death but not re	esulting in the ur	nderlying cause giv	ven in Part I.			e to the cause of death? Probably 4 X Unknown
Division of Vital Records,	he law req te has bee age 2 sho	omplet						24a. Was an autopsy performe	prior	autopsy findings available to completion of cause of 1? Yes 2 No
tal F	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	lospital:		1.0	ace of Death (Check		- 100	Tes 2 INO
of Vi	Physi r this c eral dir	<u>ن</u> کو	27. Magner of Death	1 Nation 2 28a. Date of injury	ER/Outpatient	3 DOA Othe	4 🖂 Nursing Ho	ome 5 Residence 28d. Describe how		pecify)
ono	ending eath. or: Afte the fune	ficate	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	work	? Yes 2 □ No	Edd, Describe Now	injury socialisa	
Divisi	ital or Att ars after d ral Directu lled in by	Medical Certificate: To	4 Homicide determined	building, etc. (Speci	fy)			City or Town, S	State)	Rural Route Number,
	he Hosp in 24 hou he Funei pletely fi	Medic	(Check 2 Medical Examin	cian: To the best of my knower: On the basis of examination Practitioner: To the best of	on and/or investi	gation, in my opinio	on, death occurred at	the time, date and p	place, and due to t	he cause(s) and manner stated.
	Nith Con		29b. Signature and title of certifier			29c. License			d. Date signed <i>(Mo</i>	
	BK	12	30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, Pr	int) St.	SALISBU	in mo	21801	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Darke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month &:∞p[™] E November 2011 Medical 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Memorial Home Tahrney Boons boro Kerdy Birth cace (State or Foreign Country) 5. Social Security Number 8. Date of Birth If Under 7. Age (In yrs. last birthday) 24 Hrs. **Funeral** Min. 92 1 M 2 X F 233-68-4014 Director WEST /29/1919 VIRGINIA Usual Residence of Decedent 28a-f shov at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director must be notified INWOOD W BERKELEY 1 🗌 Yes 2 🔽 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 25428 65 CARDINAL DRIVE USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify WHITE Specify. "natural". Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r HEALTH CARE Elementary/Seconday (0-12) College (1-4 or 5+) NURSING ASSISTANT 8 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARY OLIVE BAILEY HENRY FRANKLIN LIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 159 CARDINAL DRIVE, INWOOD, WV 25428 NANCY HOVATTER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State MARTINSBURG, WV PLEASANT VIEW MEM. GDS. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, MARTINSBURG, WV 25402 327 W. KING ST., (D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) meritio Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page perform 2 🗀 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 2 No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 1 🔀 Natural 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registran Signatu

Manaha

R093556

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 6°, 2011^{ear} 8:20 Рм Robert John Brady Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Woodsboro Frederick 667 W. Adams Circle ocial Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 207-24-9930 Months Hours (Month, Day, Ye Director 1**X**] M 2 □ F Dec. 1, 1933 Yrs Pennsylvania Usual Residence of Decedent 28a-f show 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 XYes 2 No MD Frederick Woodsboro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 667 W. Adams Circle 21798 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 9 þ 1 Never Married 2 Married 1X Yes 2 No If Yes, 1951 – 1954 Year of Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", 3 X Widowed 4 □ Divorced Completed h and Mental Hygiene.
It is marked other than "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Mechanic Automotive 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Brady Lillian Miller : If item 27 is marke or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7092 Fern Lane, Middletown, Maryland 21769 Robert Brady Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or otl once, ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory 11/10/2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keenevd&ddBasford P.A. Funeral Home MO1612 106 E. Church St., Frederick, Maryland 21701 23a. Part J. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) neumania Medical **Examiner** Sequentially list conditions Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ gertension 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 📝 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a. Certifier 1 🌋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only on 29b. Signatu 29d. Date signed (Month, Day, Year) 11・オ・ロ Shah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

5 2011

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All Copies Are Legible. Mental Hygiene

11-06041	Please Type of Print in Black Indelible ink.	Ensure All
Cristin Morgan Carlton	State of Maryland / Department of He	alth and Me

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		1- For State Registrar		ertificate o	f Death		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, g. c c R	eg. No.	201	1 3639	
Physic Medical Exam		Decedent's Name (First, Middle,Last)						Date of Dea Month	Dav	Year	3. Time of Death 0005 hrs	
neulcai Exaiii	mer	Terrical Cristin Morgan Carlton October 27, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
		Cedar Hall Wharf Road & (oke City	i oi Dealii		Worcester			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. E										
Director		219-31-4134 1 M 2KF 20 Yrs. Months Days Hours Min. 03/29/1991 Fore										
A		Usual Residence of Decedent									10d. Inside City Limits	
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Maryland 28a-f show d at once.	햙	10e. Street and Number	er bo	Colloke	10f. Zip C			14	0= 0:1:	of What Cou	1 X Yes 2 No	
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5-00 ed with ygien of her	Con	17. Father's Name (First, Middle, Last)						(First, Middle, I		name)		
21215-0036 21215-0036 ould be filed within 7 Mental Hygiene. marked other than	Be	Harvey Robert C	arlton, Jr	•		Line	da G	. Hatt	con			
D 21 should nd Me is ma	٢	19a Informant's Name/Relationship (Ty Harvey R. Carlt		19b. Mailin	g Address	(Street and Nur	mber or R	lural Route Num	nber, City o	or Town, State	, Zip Code) 1 1	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien and Department of Health and Mental Hygien and Line and Line 23a, or 23a-fahe Important. If item 77 in marked other than "natural", or item 23a or 23a-fahe injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition	<u> </u>	o. Place of Dispos			TT-	Date		ation - City or		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Surial 2 Cremation 3					111/	01/201	i	-		
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Physician		23a. Part I. Enter the disease, or compli- failure. List only one cause on each		th. Do not enter t	the mode of	dying, such as	cardiac or	respiratory arre	est, shock,	or heart	Approximate Interval Between Onset and	
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Box 687 death certifine the attending and for use as t	Physician/	1 Yes 2 No 9 V Unknown	9 Unknown	sealin 5 O	ther (Specify	"			1		8	
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as the		Part II. Other significant conditions	ontributing to death but not	resulting in the	underlying ca	ause given in Pa	art I.				the cause of death?	
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of Vital Records, ag Physician: The law requir Uter this certificate has been someral director, page 2 should	Completed							24a. Was a autop	sy	prior to d	topsy findings available completion of cause of	
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Division tal or Attendi rs after death. al Director: A	ficat	2 Accident Investigation	28e Place of Injury - At	home, farm, stree				28f. Location (S	Street and f	Number or Ru	ral Route Number, City	
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To the Hos within 24 h To the Fun	Medical	a	on the basis of examination nd manner stated.	and/or investigat				the time, date				
	≥	29b. Signature and title of certifier	. 0			icense number					nth, Day, Year)	
		Cer (1111	11/1			D.C.M.E.			Octobe	er 27, 201 ⁻		
712	ļ	 Name and address of person who co Zabiullah Ali, M.D. Assist 	mpleted cause of de th (Ite ant Medical Examine		Baltimore:	Street. Balti	imore. I	MD 21223				
S	ate	31. Date filed (Mon) 27 37 1 20	32. Registrar's Signa									
Regist		HEF-3/1 20	1 March	M. Maa	Mes							

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Records,

Division of Vital

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DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 0009 M INTON 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) 10/13/1919 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 □ F Months Hours 201-22-4008 92 Country) **Director** DE Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Yes 2XXNo ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2131 Davidsonville Rd. 21114 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1**XX**Yes 2 ☐ No **WWII** Black, White, etc. o ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: Completed 3 KWidowed 4 ☐ Divorced If Yes. Give Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Army National Guard Shop Chief Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Russell Clinton Helen Sentman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 234 Maryland Ave. Beverly Beach Edgewater, MD 21037 permit. Page 1 and. Department of Healt Important: If item 2 any injury or other t George E. Clinton 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Gracelawn Memorial Park 10/27/11 4 ☐ Donation 5 ☐ Other (Specify) New Castle, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir attending physician and for use as the burial-transi Due to (or as a consequence of Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 3 ☐ Probably 4 ☐ Unknown Completed ASPIRATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons 2 🗌 No ☐ Yes 1 Yes Hospital or Attending Physician; ا 24 hours after death. Funeral Director: After this صطنائات 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 1. Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending iniury work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Prantoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) refense Huy Annapalis MD 21401

DHMH 17 Rev 7/2009

Registrar

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OrlA 10 201 Medical 4c County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number Stanford 2646 ACE WAldorf If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F 69 5806 VIVGINIA Director 28a-f shov 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Funeral Director MD Aldorf 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 D'Never Married 2 D Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Black Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Entry lelephone Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANFORD PLACE WALdorf Department of Health Important: If item 27 any injury or other th 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 ☐ Cremation 3 ☐ Removal from State Lexandria 05/2011 4 ☐ Donation 5 ☐ Other (Specify) Home 22. Name and Address of Facility Greene funeral 21. Signature of Funeral Service Licenses 814 Franklin Alexandria VA 22314 ST. 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and thed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1
Yes 2 No Year Day Pregnant at time of death n signed by the a 9 Unknown 9 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work' 1 Tes 2 No Investigation Suicide Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
NOV 0 2 2011 32. Registrar's Signature State Registrar

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		For State			State of	of Ma	arylan				Health and	Mental Hy	/gien	e	O 1	,	0610
		Registrar 1. Decedent's Name	o (Eimt Middl	n / act)				<u>Cer</u>	tificate	e or L	Jeath	2. Date of D	Reg. N	0.		10.7	36411
Physicia		Mary Ann Parks Dietz												ñ. 2	∩ ^{Year}		ime of Death 45 P M
Medic Examin		4a. Facility Name (if		Town, or	r Location of Dear			c. County									
		Asbury-Sc	r-Solomons Health Care Center Solomons											Calv	ert		
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or 28	Ē	10e. Street and Nun	nber				10f. Zip Code						10g. Citizen of What Co				
s 23a	Funeral Director	11450 Asb	oury Ci	rcle	, Apt	. #	#218 20688						United States				
death item ner n		11. Marital Status			. Was Dece Armed Fo	rces?		S. 13. \	Vas Decec f Yes, spec	lent of Hi	ispanic Origin? (S ın, Mexican, Puer	pecify Yes or No to Rican, etc.)	þ.a.	14. Race - American Indian, Black, White, etc.			ian,
after al", or xami	d by	1 ☐ Never Marr 3 👿 Widowed			1 Yes If Yes, Giv Year or D	/e	No		Specify:			Specify.					
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nd 2 shoul ealth and I m 27 is m		19a. Informant's Name/Relationship (Type, Print) William E. Dietz – Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4317 Millwood Road, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State													71		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 🔲 Burial 2 4 🗋 Donation	X Cremation		moval from	State	1 0	emetery cren	natory or o	ther place	matory 1	Date 0-31-11	1		-		rginia
permit. Depart Import any inj		21. Signature of Fur	neral Service	icensee	_			- 1			ss of Facility x 600, I	Rausch usby, M					. A.
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(e) Hz (c)	<u>a</u>																
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N Vit		29b. Signature and t	m	ind	,		m-		D	. License 1942	e number 27			ate signer			
laid 8		30. Name and addre	T. Mu		MD :	130	Hosp	pital E		Suit	e 300, I	rince F	rede	erick	, M	D 20	678
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			Registrar 1. Decedent's Name (First, Middle, Last)		Ochtmoate of E	Joan	2. Date of De	Reg. No. ()	3. Time of Death
	Physici Medi	cal	Fydella M.				Detob		0/1 0/00 M
4	Exami	ner	4a. Facility Name (if not institution, give street MARY ON TO EN	eral Hospit	al Balti	r Location of Death	City	4c. County of	Death
Ī	Funeral Director		5. Social Security Number 6. Sex 214-34-6730 1 □ M	2 1x F 7. Age (In yrs. last bi	rthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Mar. 7	th ay, Year 21	D. Birthplace (State or Foreign Country)
	and show s at	ō	Usual Residence of Decedent 10a. State 10b. County	1	vn or Location				10d. Inside City Limits
	e Mary r 28a-f notifie	Director	MD 10e. Street and Number	В	altimore 10f. Zip Code		T T		1 X Yes 2 No
	with th	Funeral	3408 Lynchester H	Road	21215	5		10g. Citizen of Wha	at Country?
6	r death or items	y Fun	A P	Vas Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto			American Indian, White, etc.
700	urs afte ural", c	ted by	o TYME I I I I	☐ Yes 2 👿 No f Yes, Give ⁄ear or Dates.	1 ☐ Yes 2x No	Specify:		Specify:	Black
MN 7	ithin 72 hou ene. r than "nat the Medica	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Seconday (0-12)		a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) Domestic	during most of work	ing	Someon Home	e Else's
/e//a	12 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show ranumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) John Wesley Wil	lls			e (First, Middle, Susan	Maiden Surname) Randal	1
della Maryla	2 shoul th and I 7 is ma trauma		19a. Informant's Name/Relationship (Type, Pa Alberta C. Brown/		b. Mailing Address (Street B408 Lynche				
	1 and of Heall item 2		20a. Method of Disposition	20b. Place	of Disposition (Name of	:	Date	20c. Location - Ci	
FyG Baltimore.	t. Page tment (tant; II		1 Burial 2 □ Cremation 3 □ Remode Donation 5 □ Other (Specify)	Ft. I	ery, crematory or other place incoln Cen	:	/2011	Brentw	
Ba	permit. Page 1 and 2 should be file Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licensee Bladen G. S	ewelf	22. Name and Addre	ess of Facility Se Ses Beac	well F h Rd.	uneral Prince	Home, P.A. Fred.,MD2067
	Dhysinian		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause (Final	use on each line.	not enter the mode of dyin	ng, such as cardiac o	or respiratory a	rest,	Approximate Interval Between Onset and Death
	Physician/		disease or condition resulting in death)	Due to (or as a consequence	10f): 0 ()	D.i.			
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P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician is completed filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy Live Birth 2 Fetal dea Pregnant at time of death Dunknown	th 3 Ectopic pregnand 5 Other (specify)	cy		23d. Date o Month	
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of Vi	g Physi er this c eral dir	e: 70	27. Manner of Death 2	1 Inpatient 2 ER/C 8a. Date of injury 28b.	Time of 28c. Injur	4 ☐ Nursing Ho		dence 6 Other (Specify)
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Division of Vital Records,	oital or At urs after o rral Direct illed in by		4 ☐ Homicide determined	Se. Place of Injury - At home, 1 building, etc. (Specify)			City or To	wn, State)	or Rural Route Number,
	ne Hosp n 24 ho ne Fune oleted fi	Medical	(Check 2 Medical Examiner: C	To the best of my knowledge on the basis of examination and ctioner: To the best of my know	or investigation, in my opinion	on, death occurred a	t the time, date	and place, and due to	the cause(s) and manner stated.
_	To the		29b. Signature and title of certifier		29c. Licens	e number 9 (o 58		29d. Date signed (A	
1	RW 4		30-Name and address of person who comple	eted cause of death (Item 23a)	(Type, Print)	Como	1 Nac	notal	
0	Sta	te	31. Date filed (Month, Day, Year)	32. Registrars Signature	Makyland	JUKIA	(1405	riuc	
	Registr		16-24-11 OCT 282	1919 Person	a ponker	9			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ october 31, 2011 11:30 A M M. Imogene Doub Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Washington Hagerstown Somerford House 9. Birthplace (State or Foreign Country) Texas If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** May 18, 1917 Days Hours 1 M 2 XX 94 Director 330-24-8558 Usual Residence of Decedent show 10d. Inside City Limits 3a or 28a-f show be notified at 10b. County 10c. City, Town or Location 10a, State within 72 hours after death with the Maryland Director 1 Tyes 2XXNo Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a Funeral USA 21740 10116 Sharpsburg Pike Examiner must 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes XX No If Yes, Give Year or Dates. Black, White, etc. or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🙀 No Specify: Specify: "natural", ¾X Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Housewife other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nettie Louise Tucker Frederick Frank Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Williamsport, MD 21795 10541 Governor Lane Blvd. Terry R. Doub - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other /Sec. ** any injury or Williamsport, Maryland 11-5-2011 Greenlawn Mem. Park 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funera Williamsport, MD 21795 425 S. Conococheague St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ATRILL FIBRILLATION 2W MOV Medical resulting in death) Due to (or as a consequence of) Examiner CARDIO VALLULAR YRS ARTERIO SCLEROTIC Sequentially list conditions, Due to (or as a consequence of): DUSKASE Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical Box 68760 IE EEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 ¥ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown EMROLISM Records, PULMONARY page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PULMONARY DISEASE OBSTRUCTIVE has autopsy performed? 1 Yes certificate KTPERTENSION 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be SUMERIORE examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) A645 1 Inpatient 2 ER/Outpatient 3 IDOA ပ To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this of completed filled in by the funeral director. After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No 1 Natural injury 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00018019 OME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

VASANT

TW-3

MIII ST. HAGERSTOWN MD

340

Registrar's Signature

DATTA

e in

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

ORIGII

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OCME

Donna M. Vincenti, MD

31. Date filed (Month, Cay, Year) 2011

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

			For State of	Maryland		rtment of H tificate of D		Mental Hyg	eg. No. 201	1 36405					
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat October		3. Time of Death 04:20 P M					
	Medic Examin	al	Genevieve Z. Darling 4a. Facility Name (if not institution, give street and num.	ber)		4b. City, Town, or	Location of Dea		4c. County of Death						
	LXaiiiii		South River Health & Rehab. Ce			Edgewat	er		Anne Arundel						
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🔏 F	7. Age (In yrs. Ia 94	st birthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	n. (Month, Day,	Year) C	irthplace (State or Foreign ountry)					
	3		Usual Residence of Decedent 10a, State 10b. County		, Town or Loc	ation		02/26/19	917 MIC	higan 10d. Inside City Limits					
	larylan 8a-f sh ified a	Director	Maryland Anne Arundel		gewate					1 🗆 Yes 2 🎦 No					
	a or 28 be not	al Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of What C						
	ath with	Funeral	1731 Tacoma Road 11. Marital Status 12. Was Decei	dent Ever in U.S	13. W	21037	spanic Origin? (5		nited Stat	14. Race - American Indian,					
õ	ter dea , or ite	by F	Armed For 1 Never Married 2 Married 1 Yes. Give	ces? 2 🗓 No		Yes, specify Cubar ☐ Yes 2 🛣 No		Specify Yes or No- rto Rican, etc.)	Black, Wh	Black, White, etc. Specify: White					
ခို	be filed within 72 hours after death with the Maryland antal By yigne. ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show the other than "natural".	eted	3 ¥ Widowed 4 □ Divorced Year or Da 15. Decedent's Education			ent's Usual Occupa			16b. Kind of Busines						
ذ 212	in 72 h e. nan "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4 or 5+)	(Give k life. DC	ind of work done d NOT use retired)	uring most of w	orking							
17.5	d with	Be Co	12 17. Father's Name (First, Middle, Last)		Secret	ary	18 Mother's N	ame (First, Middle, M	Veterans Adm Maiden Surname)	inistration					
lanc	l be file lental l rked o tic eve	To E	Otto A.E. Zemke					nce Bevie:							
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be file Department of Health and Mental I Important: If them 27 is marked o any injury or other traumatic eve once.		19a. Informant's Name/Relationship (Type, Print)			-			City or Town, State, 2						
e, S	and 2 Health tem 27		Dennis Darling/Son 20a. Method of Disposition	20b. P	ace of Dispos	sition (Name of			Maryland 2						
E C	Page 1 nent of int: If ii		1 ☐ Burial 2 ☐ Cremation 3 🔏 Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State C	emetery, crem h 1ehem C	atory or other plac	10/	/31/2011	Ann Arbor	, MI					
Saltı	ermit. lepartm nporta ny inju		Kalas Fune												
	<u> </u>	2973 Solomons Island Road, Edgewate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,													
~ F	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition The roscient of Cavarovas Vascular cultivas of the second of the condition of the condit												
	Medical Examiner		resulting in death) a. Due to (or as a consequ	ience of):	COVI	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CYICOT							
		Jer	Sequentially list conditions, b. Due to (or as a consequ	uence of):	-									
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C												
_	cate be executed physician and s the burial-transit	al E	resulting in death) Last Due to (or as a consequ	uence of):										
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× 68	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the past 12 months?		aldeath 3 🗀	Ectopic pregnanc	ey.		23d. Date of o	delivery Day Year					
Box	r the at	ysici	1 Yes 2 No 9 Unknown	nant at time of o	death 5 L	Other (specify)			Month Day real						
О	law requires that the nas been signed by the e.2 should be detach	by Pr	Part II. Other significant conditions contributing to d	_	_		en in Part I.	1		to the cause of death?					
rds,	een sig	ted	Sich Sinus							Probably 4 Unknown					
Division of Vital Records,	e law re has by ge 2 st	Completed	Congestive , Atrial Fibri	Hear	L 5-	a1 1107 E	?		rmed? prior to death	autopsy findings available to completion of cause of					
e E	sician: The law i certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical	1144	ON -	26. <u>Pl</u>	ace of Death (C/	1 🗌 Yes heck only one)	2 🔏 No 1 🗔	Yes 2 □ No					
<u> </u>	Physici this cer al direc	은		Inpatient 2	ER/Outpatier		4 X Nursing		ence 6 Other (Sp	pecify)					
n 0	iding F th. After i	cate	27. Manner of Death 1 Manner of Death 1 Natural 28a. Date (Mon 2 Accident Investigation	th, Day, Year)	injury	28c. Injun work M 1 🗆		28d. Describe no	ow injury occurred						
/ISIO	r Atter ter dea rector restor	Certificate:	3 Suicide 6 Could not be 28e. Place	of Injury - At ho		eet, factory, office		28f. Location (S City or Town	treet and Number or . n, State)	Rural Route Number,					
á	pital o	Medical C	29a. Certifier 1 Certifying Physician: To the b	est of my know	ledge, death o	occurred at the time	e, date and plac	e, and due to the ca	use(s) and manner as	s stated.					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	nd place, and due to the cause(s) and manner	er as stated.												
_	vithi To th		29b. Signature and title of certifier	Sun	-an	29c. License	5065	3	29d. Date signed (Mo	enth, Day, Year) 8 - 2011					
	12		30. Name and address of person who completed caus 5851 - Reale C	e of death (Item	23a) (Type, F	Print) QXI	VI F	c. 51)	RANA						
	li		5851, Reale CA 31. Date filed (Manth, Pay, Year) 2014 34. R	egistrar's Signa	ture	Rowall	3	reals.	m.D	20751					
	Sta Registr		OCI 3 1 2011 2	egistrar's Signa	1. La	Med									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 01:22 OCTOBER DISHER-HAROY 2011 KENEA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number)
UNIVERSITY OF MANYCAND
22 SOUTH CHEENE ST City, Town, or Location of Death Examiner BALTIMORE . Social Security Number CHEENE Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) May 14 1967 **Funeral** 1 M 2 X F Days Hours NY Yrs. 44 **Director** 110-64-9013 Usual Residence of Decedent 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 🙀 Yes 2 🗆 No Waldorf MD Charles 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral United States 20601 2181 Everett Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Š 1 Never Married 2 X Married 1 XYes 2 ☐ No If Yes, Give Maryland 21215-0036 Yes 🗶 No Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Systems Administrator Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Edna Ravenell Sidney Disher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2181 Everett Court, Waldorf, <u>Christopher Hardy/ Husband</u> Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Mary Fand Weterans 1

Burial 2 □ Cremation 3 □ Removal from State 11/8/2011 Cheltenham, MD 4 Donation 5 Other (Specify) Cemetery at Cheltenham 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Livensee 5538 Marlboro Pike, Forestville,MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPERGILLUS disease or condition resulting in death) INFECTION Medical Due to (or as a consequence of) **Examiner** ACUTE MYELOGENOUS Sequentially list conditions, Examine Due to (or as a consequence of) of any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iiniury the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year for 1 ☐ Yes 2 ≥ 9 ☐ Unknown been signed by the s should be detached 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown MYENDFIBROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? has page 2 2 No 1 X Yes 2 ☐ No 1 Yes After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 📉 No 26. Place of Death (Check only one) **Division of Vital** funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 Pending 1 X Natural Accident 24 hours after death. Funeral Director: A Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifier

State

SOUTH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1316172240

MICHAEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland 12 Penartment of Health and Mental Hygiene 2 0 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ :25% M TARDWICK TREAKLE 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF BALTIMORE MANULAND MED. CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) 1/20/1919 1 □ M 2 👿 F Months Hours Virginia 577-01-4196 91 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at with the Maryland Director 1 ☐ Yes 2 🛣 No White Plains Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20695 USA 4210 Southwinds Place permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Administrator St. Elizabeth's Hosp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Henry Treakle Inez Hardwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee V. Dickinson/Son 8810 Surrey Court, Alexandria, VA 22309 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
MD. Veterans Cem. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/7/2011 Cheltenham, MD 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 21. Signatura f Funeral Service Licer ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is on each line. Part. Enter the disease or complicat shock, or heart failure. List only one ca Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TRACEREARAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of; CERTIFICATION APPROVED BY MEDICAL attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? has Hospital or Attending Physician: The 24 hours after death.Funeral Director: After this certificate I Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 X Natural 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the l only one) 29b. Signature and title of certifie 1568761732 Mame and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST. BALTIMORE MD 2/201

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death November 4. Physician/ A^{M} 2011 8:50 Droneburg, Sr. Claude Hendrix Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 307 East Third Street Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Feb. 8, 1919 Days Hours Director 216-30-3257 92 Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The stem 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director Frederick 1 X Yes 2 ☐ No Marvland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 307 East Third Street 21701 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 7th Agriculture Dairy Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Claude Thomas Droneburg Catherine Rebecca Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 East Third Street, Frederick, Maryland 21701 Claude H. Droneburg, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 7. 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Frederick, Maryland Olivet Cemetery Mt. 21. Signature of Funeral Service Licensee Keeney And Basford PA Funeral Home, MO1473 106 East Church Street, Frederick, Maryland 21701 23a. Rand 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. **Onset** and Death Immediate Cause (Final Physician/ ormany disease or condition Medical resulting in death) Due to (or as a consequen sof) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Vear Pregnant at time of death 2 No g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops\ death? within 24 hours after death.

To the Funeral Director, After this certificate homeletely filled in by the funeral director, pag-1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ustin 109689 20112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Austin Pearre,

31. Date filed (Month, Day, Year) NOV 1 5 2011

M.D.

32. Registrar's Signature

300 West Ninth Street, Frederick, Maryland 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ ROBERT EDDINS 5:30 AM^M OCTOBER 2011 26 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** KENT CHESTERTOWN 23051 OLD FAIRLEE ROAD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign Sex 1 M M 2 □ F **Funeral** LOUISIANA Months Hours 12-18-1945 417-72-8053 65 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 X No CHESTERTOWN KENT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō ms 23a or must be n Funeral 23051 OLD FAIRLEE ROAD UNITED STATES 21620 items ; . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status "natural", or iter Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes Give Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DISABLED Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ MARY JANE LAMBERT ALFRED EDDINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY DARLENE RIVERA/NIECE 23051 OLD FAIRLEE RD. CHESTERTOWN, MD 21620 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State CHURCH HILL CEMETERY 10-30-2011 CHURCH HILL, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND . Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Or set and Death Immediate Cause (Final Physician/ Carcinoma MANA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Mronie Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown the. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 hypothyord Unknowr 1 🗌 Yes 2 🗌 No 3 🗌 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ Certificate: To 1 🗌 Yes ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director: After of the funeral completed filled in by the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled jury work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Oertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 29c. License number De021 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

State

Registrar

31. Date filed (Month)

31

OCT

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mont 2011 9:15 a^M Moena L. Fontanilla October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince George's 708 Somerset Hyattsville Place If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🏲 F (Month Day, Year) Uvalda, G.A. **Director** 77 256-48-0596 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. The state of Health and Mental Hyglene. The state of The marked other than "natural", or items 23a or 28a-f sho lant if item 27 is marked other than "natural", or items 23a or 28a-f sho lant items to return the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Yes 2 No Hyattsville MD Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20783 United States 708 Somerset Place 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other thar event, the M Elementary/Seconday (0-12) College (1-4 or 5+) P.G. County School Sys Cafeteria Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Amanda Denton Alva Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532 Fox Feild Cir Germantown, MD 20876 permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other tr once, Karen D. Ward/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11-1-2011 Brentwood, MD 21. Signature of uneral Service ace 22. Name and Address of Facility Fort Lincoln Funeral Home B401 Bladensburg Rd. Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

R4

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael SELAND 730'S BALTIMILE BLVI) 107 CILIZE PATH MIS

31. Date filed (Month, Day Year)

32. Registrar's Signature

NOV 0 1 2011 Leven B. Sauch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Beatrice Rose Feldshue Medical October 2011 840 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Min 03/127/14929 174-22-2968 82 Director 1 - M 2 X F Pittsburgh, PA Usual Residence of Decede 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code items 23a or 10a. Citizen of What Country? Funeral 9905 Bald Cypress Drive 20850 <u>United States</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify "natural", 3 X Widowed 4 Divorced Specify: White Completed marked other than "natur matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Louis Kravitz Yetta Brown .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Elyse Renee Weiner - daughter 9905 Bald Cypress Drive Rockville MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, National Crematory 1 Burial 2 Cremation 3 Removal from State 10/27/11 Falls Church, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction Inc MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Mood Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Frailty that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death 1 ☐ Yes ≥ L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 Yes 2 X No Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 X No funeral director, Be 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending within 24 hours after death.

To the Funeral Director, Aft

Completely filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/24/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta MD 3000 North Ridge Road Ellicott City MD 21043 31. Date filed (Month, Day, Year) OCT 3 1 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 9:40 A M Eli Freeman Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Aberdeen Chesapeake Court Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** (Month, Day, Year) av 1, 1930 Country) 1 X M 2 🗆 F Months Days Hours 180-22-2768 **Director** 81 May Usual Residence of Decedent or 28a-f show 10a. State 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 □ No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Swan Street 21001 U.S.A. should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 X Yes 2 □ No 1952-Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed 1954 White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Construction Heavy Equipment Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be Department of Health and Ments Important If item 27 is marked any injury or any Margaret Ann Lewis Thomas Eli Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Swan Street, Aberdeen, MD 21001 Elizabeth Freeman/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State Stewartstown Cemetery Nov. 10,2011 Stewartstown, PA 4 Donation 5 Other (Specify) 21. Signature of Frineral Survey Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 19 S. Main St., Stewartstown, PA 17363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition dano Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last tending physician a r use as the burial-Physician/Medical Box 68760 attending IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the a Unknown 9 I linknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law cate has page 2 s autopsy death? After this certificate Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be rep Daughters Hospital: 2 🖾 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident 24 hours after death. Funeral Director: Al Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) Name and address properson who completed cause of death (Item 23a)

DHMH 17 Rev 7/2009

State

Registrar

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:15 P M Robert Joseph Forshaw November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hancock 7900 Millstone Road Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min (Month, Day, Year) 2/16/1940 Hours 1 💢 M 2 🗆 F Director NY 239-64-4698 70 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7900 Millstone Road 21750 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 10.5 9. € 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates.1958-61 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene Important, If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Officer/Major State Government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Marie Ann Dragg Robert James Forshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Millstone Road Hancock, MD 21750 A. Forshaw/Wife Caro1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State Flintstone,MD 11/07/2011 4 Donation 5 Other (Specify) Rocky Gap Veterans 21. Sonature Funeral Service License 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 MO0260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ yocardial intercti Medical resulting in death) Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown q 🗌 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1-X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 4, 2011 D56048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

NOV 1 5

Ave. Hancock, Maryland

Pennsylvania

No: 4h

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30 October ŽÖ11 Brian Scott Gregory 8:43 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7660 Fairplay Road Washington Boonsboro Social Security Number Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** M 2 □ F Months Days Hours June 22,1951 West Virginia 212-58-7500 Director 60 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Id be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tyes 2XXNo Maryland Washington Boonsboro 10e. Street and Numbe 10g. Citizen of What Country? Funeral 7660 Fairplay Road 21713 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes No If Yes, Give Black, White, etc. 1 Never Married XX Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Manufacturer Emissions Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Harold Franklin Gregory Elinor Hardy Jean .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Gregory - Wife 7660 Fairplay Road Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Nov.1,2011 Hagerstown, Maryland Signat Funeral Service License sborned Runeral Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Infiltrative Cardiomyopathy Medical resulting in death) Due to (or as a consequence of) Examiner 3 months Amyloidosis Sequentially list conditions, if any, healing to immediate cause. Enter Underlying Examiner Due to lor as a consequence of Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Asthma 24a, Was an has performed within 24 hours after death.

To the Funeral Director, After this certificate 1 Yes 2 No 2 X No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2XXNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred XNatural (Month, Day, Year) 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by determined the Hospital ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0056413 October 31,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-8 Sanjay Saxena, MD 1138 Opal Court Hagerstown, Maryland

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 (Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** harles Delano October 11:56 A M 1105 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Villa Rosa Nursing Home Prince George's Mitchellville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 578-56-4420 Director 66 11/12/1944 DC Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Prince George's 1 ▼Yes 2 No Director Forestville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n death with 2900 Norman Drive 20747 Funeral United States 7 is marked other than "natural", or items traumatic event, the Medical Examiner man 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ Computer Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles J. Givens Anna Toms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest A. Givens/ Wife 2900 Norman Drive, Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place Mary Land Veterans 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery at Cheltenham 11/10/2011 Cheltenham, 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20746 M00851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner foot gangrene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed physician and s the burial-transit Peripheral Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical ld guipt lse as t IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery for 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has page performed' 2 1No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Wursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cne 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CK

State Registrar 31. Date filed (Month, Day, Year) NOV 0 2 2011

32: Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Ste Zeis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Alexander Gibson November 2011 0735 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death 71 Second Street Ceci1 Chesapeake City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days AUG 12 Year 918 Maryland **Director** 034-05-4457 93 Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 Chesapeake City 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be 1 Funeral 71 Second Street 21915 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S.
Armed Forces? World
1 M Yes 2 No
If Yes, Give War II 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Divorced Specify. Completed White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Superintendent Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Otha W. Gibson Ella Verna Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Gibson/Wife 71 Second Street, Chesapeake City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 9 ■ Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) Hopewell Cemetery Port Deposit, MD 2011 ure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Sign 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) 20mi Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury -transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Live Birth 2 ☐ Fetal dea
☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural (Month, Day, Year) 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No 3 Suicide 4 Homicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur nd title of certifi 29c. License number 29d. Date signed (Month. Dav. Year) 04471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GRACE Month 5:30 AM ONES 20 \ I Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE MD PARK CATONSVILLE Summil 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Dec 12 Country) Hours Min. 1 M 2 XF Director 95 Yrs. 221-14-5935 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 801 Winters Lane, Apt. 325 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 😾 No timore, Maryland 21215-0036 African-1 ☐ Yes 2 No Specify. Completed 3 XWidowed 4 Divorced American Year or Dates event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Casino 10th Culinary Assistant Be perfiit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cyrus Derrickson Sarah E. Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shamekia Wilson-Price 15115 Greenwing Terrace, Upper Marlboro, MD 20774 niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Springhill Memory 4 Donation 5 Other (Specify) 10/28/2011 Hebron, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EMENTIA Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** m under Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of sician and burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician the derivation that the the purial Physician/Medical ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Yea Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ER TENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hours after death.
 Funeral Director: After this certificate by 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D007 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATINONE DD 4229 WILKENS #204 TANSINDA 3453 ANE

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Year

26

park

egistrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ xun leen 015 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Gounty of Death **Examiner** 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 7. Alge (In yrs. last birthday) Country)
MARYLAND 1 □ M 2 □**X**F Days 8-25-1948 Hours Min. **Director** 218-50-1314 63 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 5536 EASTERN NECK RD. UNITED STATES 21661 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 XWidowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 CUSTOMER SERVICE REPRESENTATIVE FINANCIAL injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BOBBY OWEN CLARK SR. LORETTA MAE KENDALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KARA CHIPOURAS/DAUGHTER 819 HALEY ST. MIDDLETOWN, DE 19709 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL 11-2-2011 ROCK HALL, MARYLAND 21. Signature of Funer | Serve Lice fellows, helfenbein & Newnam 130 Speer RD, Chestertown, MD any FUNERAL HOME P.A. D 21620 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 4 hours Immediate Cause (Final Physician/ disease or condition resulting in death) Multiorgan Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 1 7 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an erformed' 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 110 1 Yes မ 1 Inpatient 2 [ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? s after death. 1 🗌 Yes Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 28 M COON 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year

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32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death ^D3, Physician/ 2**011** Juanita Moody Harned-Bryden November 3:20 \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buckingham's Choice Frederick Adamstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 259-03-8980 94 Georgia Director March Usual Residence of Decedent 28a-f shov 10c. City, Town or Location at 10a. State 10b. County 10d. Inside City Limits Director items 23a or 28a-f s er must be notified Md. Frederck Adams town 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3200 Bakercircle #H-022 21710 U.S.A death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Examiner Black, White, etc. 5 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Completed 3X□ Widowed 4 □ Divorced White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry tal Hygiene. Ser than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked or ٩ Floyd Moody Inez Putman other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or any <u>Melissa Zelman (Daughter)</u> 5642 Morning Glory Trail New Market, Md. 20b. Place of Disposition (Name of Nov. 6, 2011 20c. Smithsburg. Md. 1 🗆 Burial 2 💢 Cremation 3 🗖 Removal from State Smithsburg Crematory 4 Donation 5 Other (Specify) 12525 Bradbury Ave. . Signature of Funeral Service Licensee 22. Name and Address of Facility Davis Funeral Home Smithsburg, Md. 21783 M01414 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition neumenio Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical that the death certificate be P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown Year õ Month Dav Pregnant at time of death the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed er + ension peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? this certificate 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital Other: 2 No ဂ္ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at work? within 24 hours after deau...

To the Funeral Director: After t Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 1 Tyes Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or e 29b. Signatu title of certifie 29d. Date signed (Month, Day, Year) HITEP 5hox 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Barbara Kay Hous	1	l - For State legistrar	Sta	ate of Mary	land / [ment of <i>ficate of</i>			Menta	al Hyg		eg. No.	20		1 3642
Physician	7	1. Decedent's Name										Date of Dea Month	ith Day	Year		3. Time of Death
Medical Examine		Barbara 4a. Facility Name (if			aumbar\		1.	4h City T	our or le	ention of		Novembe	r 1, 20	011 c. County of	Death	0923 hrs
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Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other fr	-	1 X Burial 2			from State	1	matory or othe Hill		eterv	,	11/7	/11	Ha	gerst	own	, Maryland
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Physician Wedical	1	23a. Part I. Enter the failure. List only		on each line.			o not enter tr	ne mode o	t ayıng, su	ich as car	diac or re	espiratory arr	est, sno	ock, or near	17	Approximate Interval Between Onset and Death
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D. Box 6876. the death certificate by the attending phy treed for use as the Physician/M.		past 12 months?		4 Pres	gnant at tim	e of death	- 1	tal death her (Spec		_cctopic p	or egrianic	у	Į	WOTIG	D	iy (eai
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Division of Vital Records, P.O. Box 6876 tall or Attending Physician: The law requires that the death certificate its after death. *I Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the bertification: To Be Completed by Physician/M		Part II. Other signif	icant conditi	Jils contributing	to death bi	it not resu	iting in the u	indenying	cause giv	en in Pari	1.					ably 4 Unknown
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risior Attencer death		2 Accident	Inves	igation Oct 31			753 hrs e, farm, stree	et, factory,				3f, Location (Street a	and Number	or Rura	al Route Number, City
Division or spital or Attending hours after death. neral Director: After filled in by the funer Certification:		3 Suicide 4 Homicide		not be nined (Specifi	garag	е					19	or Town, S 808 Marvin	State) Aveni	ue, Hagers	town,	MD
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the the Medical Certification: To Be Completed by Physician/M.				ysician: To the b	s of examin											
and manner stated. 29b. Signature and title of certifier 29c. License number													29d.	Date signed	(Mon	th, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 27 201^T LORAINE C. HABERMAN 11:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 91 Months Days Hours 1170171919 MARYLAND 221-14-7753 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c, City, Town or Location Director 1 Tes 2 X No MD QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 GOLT ROAD 21619 UNITED STATES death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? 1 ☐ Yes 2 💢 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. Hygiene. other than "natural", or 1 Never Married 2 Married 72 hours after 9 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: WHITE 3 Widowed 4 X Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 11 NURSE HEALTH CARE marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental f ဂ CLINTON B. BAKER LILLY MANSFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is REBECCA THOMPSON / DAUGHTER 114 GOLT ROAD, CHESTER, MD 21619 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 🌠 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 10/31/2011 EASTON, MD 21. Signature of Suneral Sewice Licensee P.A. NEWNAM FUNERAL HOME, P.A. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. any OWS, HELFENBEL SHAMROCK ROAD, CHESTER, 23a. Part 1. Enter the disease, or complications that sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause o Immediate Cause (Final Onset and ea Physician/ disease or condition resulting in death) Medical **Examiner** Esquentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury oars To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence physician /Medical Box 68760 as the nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) ed by the a detached f g Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed , page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

Cropley

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -0)PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Chesapeake Hospice House Harwood If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min Director 577-28-5313 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c, City, Town or Location Director 1 Yes 2X No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral USA 21401 2509 Painter Ct. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11 Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 6 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary L. Klein Otto Gerhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Painter Ct., Annapolis, MD 21401 David W. Harry / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 🗆 Other (Specify) 10/28/2011 Edgewater, MD Kalas Crematory 21. Sign ice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd.. Edgewater. MD 21037 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine that y, reading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans and Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Registrar

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30, Name and address of pere

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31. Date filed (Month, Day, Year) 0CT 3 1 2011

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th (Item 23a) (Type, Print)

32. Registrar's Signature

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To the Funeral Director A.

Completed filled in by the fu 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier d address of person who completed cause of death tem 23a) (Type, Print) 32. Registrar's Signature State

Registrar

Henry

Della

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Margaret Hobbs Α. 30 2011 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/20/1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 200 577-68-8370 83 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show M. dical Examiner must be notified at 1 ☐ Yes 2 No Director Prince Frederick Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20639 USA 85 Hospital Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 翟丞No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 😾 🕍 O Specify: Specify: White þ 3√XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Assistant P.G. County permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 Is marked other thu any Injury or other traumatic event the 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugene Smith Catherine Bresnahan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Taylor / Daughter 185 Sun Park Lane Huntingtown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 Cremation 3 □ Removal from State XX Burial Md. Veterans Cem. 11/8/2011 Cheltenham, Maryland 4 Donatio 5 Other (Specify) ^{22. Name and Address of Facility} George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 of Funeral Service License 21. Signatur rech 23a. Party Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hronic **Physician** obstructive polymonary Diseas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Scizures Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Dementia attending physician and for use as the burial-tran Due to (or as a consequence of): Hypothyroidism Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 🕱 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate 2√ No To the Hospital or Attending Physician; r this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 1 ☐ Yes 2 ☑ No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 2 After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Matural 5 ☐ Pending investigation within 24 hours after com...

To the Funeral Director: After an order of the funeral black of the funeral black of the funeral filled in by the funeral filled in by the funeral funeral filled in by the funeral funeral fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one)

State

Baltimore, Maryland 21215-0036

P.O. Box 68760

or Vital Records,

Division

31. Date filed (Month, Day, Year) NOV 0 2 2011

Vijaya Guduri

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Vijaya Guduri MD 130 Hospital Road 130 Hospital Road #300 Prince Frederick, Maryland 32. Registrar's Signature

Registrar

29c. License number

D68922

29d. Date signed (Month, Day, Year)

2011

20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36425 For State Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Augustus Haughton 2011 October 0 8:00 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery **HCR Manor Care** Silver Spring 9. Birthplace (State or Foreign Country) West Jamaica, Indies Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** July 1 X M 2 🗆 F Months Hours Mir 82 **Director** 579-80-1268 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral 2501 Musgrove Road 20904 Jamaica, West Indies Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 nan "natural", e Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. **Black** Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) **9th grade** College (1-4 or 5+) the **BFI Waste Services** Sanitation Worker permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Clereeseta Jacob Haughton Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 "R" Street, S.E.; Washington, D.C. 20020 Phillip Andrew Haughton (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. II 1 X Burial 2 Cremation 3 Removal from State Heritage Memorial Cemetery Waldorf, Maryland 4 Donation 5 Other (Specify) Name and Address of Facility R. N. Horton Company Morticians, gnature of Juneral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 90 minutes Acute Cardiac Decompensation Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin that the death certificate be executed Atrial Fibrillation vears and -tran Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Division of Vital Records, Diabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of Hypertension 24a. Was an autopsy page perform<u>ed</u> death? cate Cerebrovascular Accident History 1 Yes 2 X No 1 ☐ Yes 2 ☐ No or Attending Physician: certific 25. Was case referred to medical Be director 26. Place of Death (Check only one) examiner? 2 **X** No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending ours after death.

neral Director: Ai
filled in by the fu 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a

State Registrar

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Medical

29a. Certifier

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29b. Signature and title of

30. Name and address of pe

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M.D. 32. Registar's Sign NOV O

son who completed cause of death (Item 23a) (Type, Print)

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

October 0

20878

10810 Darnestown Road; Suite 202

Gaithersburg, Maryland

2011

Certifing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death 1 Decedent's Name (First Middle | ast) Oct 28, 2011 Physician/ 9:10 AMM <u>Hardinger</u> Evelvn Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 619 White Avenue 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number 7. Age (In yrs. last birthday) Feb 23 1 □ M 2 □ **,** Director 234-56-5069 76 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any hipury or other traumatic event, the Medical Examiner must be notified as any hipury or other traumatic event, the Medical Examiner must be notified as 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 619 White Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Never Married 2 XMarried Completed by 1 ☐ Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: white Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home <u>homemaker</u> Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည Edith Shomo Carl G. Dennison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
619 White Avenue Cumberland MD 21502 James Hardinger 619 White Avenue husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Sunset Memorial Park 1 Removal from State 10/31/2011 MD Cumberland Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to lor as a consequence of Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending work? within 24 hours after death To the Funeral Director: A 1 🗌 Yes 2 🗌 No neral Director: / Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1005998

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36427 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death OCT. 24 Pay Physician/ 2011 0620 CECILIA HIGGINS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days Hours (Month, Day, Year LB. 4, 19 Months Yrs ENGLAND Director 579-68-6594 FEB 87 Usual Residence of Decede should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural" or income. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 38297 BAYBERRY LANE 19975 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER 12 OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SIDNEY HANRECK ETHEL MAY PETTIT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEE M. HIGGINS/SON 1232 WOODHILL DRIVE, KENT, OHIO 44240 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BISHOPVILLE CEMETERY | 11/5/11 4 Donation 5 Other (Specify) BISHOPVILLE, MD 21. Signature of Funeral Service License. 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Bleeding Onset and Death Physician/ ntracrahi disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes Other: XInpatient 2 □ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural

2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 \square Yes 2 🗌 No Accident Investigation

Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c, License number 00064/20 29b. Signature and title of certifier + way Drive Berlin and address of person who completed cause of geath (Item 23a) (Type, Print)

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State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 O Physician/ Year KINEA 9:30 8 KING 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** KEGIONAL PRINCE GEORGE LAUREL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2 A F Days Dec. 6, 1956 Months Hours Min. 578-78-4287 54 Yrs DC Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Germantown Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11446 Stoney Point Place 20876 United States al Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed American Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Coordinator Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Abraham King Dorothy Lee Chavis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12602 Horseshoe Bend Circle Clarksburg, Md. 19a. Informant's Name/Relationship (Type, Print) 20871 Frenise Crawford - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) November 2, Landover, Maryland 4 Donation 5 Other (Specify) Harmony 2011 Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE Washington, DC r t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) EREBRUVATU Medical Due to (or as a consequence of) Examiner JEAGINATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Jas page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o d title of certifier 29b. Signaty 100067210 10/25/2011 s of person who completed cause of death (Item 23a) (Type, Print) BUI TULL HOUSE AVE, SMIR BZ, FREDRANCK mn 2170) ONIT 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29 Myrtle Viola 1:42 p M James 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 800 Peachblossom Avenue Cambridge Dorchester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Days (Month, Day, Months Hours Min. Mary land Director 214-07-9174 99 ept. Usual Residence of Decedent shov 10a. State 10b. County Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Dorchester 28a-f Cambridge 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 800 Peachblossom Avenue 21613 USA Baltimore, Maryland 21215-0036 🔾 🕽 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give 1 ☐ Yes 2 K No Specify. white "natural", 3 ₺ Widowed 4 □ Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) unknown homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Ira B. Marshall Ella Condon permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Kersev daughter 2 Algonquin Road, Cambridge, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Spedden Seward Cem. 1 X Burial 2 Cremation 3 Removal from State 11/1/11 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral S 22. Name and Address of Facility Thomas Funeral Home P.A. any 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ heart tailure Congestive disease or condition resulting in death) Medical Examiner Zortic stenasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). physician and s the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown dementia, plnods has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page performed? certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) 2 No 1 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 24 hours after death Funeral Director: # Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Bramble St, Cambridge

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36430 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:35 A M Ctobox Louise R. Johnson 26,2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec • 25, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. 1921 Dec. Virginia 89 Director 577-32-4975 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important; or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 29 or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director 1 X Yes 2 No Mitchellville Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 1708 Kings Manor Drive 20721 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 P No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Care Taker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ George Johnson Martha Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Christian - Niece 20721 1708 Kings Manor Drive Mitchellville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Washington National 21. Signal of Juneral Service Ligan ee 22. Name and Address of Facility Stewart Funeral Home, Inc. tom! Sterry 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner lostridium difficile Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine ending physician and use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Por Day Pregnant at time of death signed by the a Part II, **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Failure to Anemia. Division of Vital Records, 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 1 Nnpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00041661 raneu M October 28, 2011

State Registrar

Johnson, Ruby

8118 Good luck Road

Lanham, MD

and address of person who completed cause of death (Item 23a) (Type, Print)

Fredista Francis MD

Box 68760 P.0. Records, Hospital or Attending Physician: The Division of Vital s after death.

Completely To the I within 2.

State Registrar

29a. Certifier

29b. Signature and title of certifie

29c. License number D01852

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Date signed (Month, Day, Year) October 24, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4203 Queensbury Rd. Paul A. DeVore, M.D. Hyattsville, Md. 20781

31. Date filed (Month, Day, Year) OCT 3 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36432 Stata 11/2/2011, M.S. Kent Co. Registrar Amended#1 Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Patrick Kevin Keehn Year Month **Physician** Hek Kevid 2:15 PM 2011 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 13646 Store Rd. Lusby
If Under 1 Year If Under 24 Hrs. Calvert 8. Date of Birth (Month, Day, Feb 16 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Country)
D.C. Days Hours 1**⊠**M 2□F 1956 55 Yrs. 578-76-4262 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location woda the Medical Examiner must be notified at 1 ☐ Yes 2 K No Director VA Fairfax Oak Hill 28e-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō U.S.A. 13514 Maverick Lane 20171 or Items 23e Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Technology Sales Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fii h and Mental H 7 is marked otl .. Pages 1 and 2 should be tment of Health and Menta tent: If item 27 is marked jury or other treumetic ev James Mark Keehn Patricia Leiss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13514 Maverick Lane Oak Hill, VA. 20171 Anne K. Keehn (wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Pagé Department of Importent: If eny injury or once. Kent Cremation Services 11/1/11 Smyrna, DE. 4 □ Donation 5 □ Other (Specify) unital Service Licensee 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Bahin Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Pnysician Colon /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attending Physicien: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deeth 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown vertebral Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Vacation 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ö

Certification: To s after dea...rel Director: Afr filled in by To the Hospitel o within 24 hours aft To the Funerel D completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D17324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merrimac Ct, Prince Frederick, MD **ब**उ८ A Noble, BAYMON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 27, 2011 Bruce Allen Kleiman 12:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Hours Min (Month, Day, Year) 218-38-6591 **Director** 1 XX X 2 □ F 69 June 22, 1942 Washington, DC Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any highry or other traumatic event, the Medical Examiner must be notified at any highry or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 Yes 2 X XNo Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4008 Underwood Street 20782 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 1 \times Yes 2 \square No 1964-Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxNo Specify: 3 Widowed 4 Divorced Specify: White Year or Dates. 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Analyst Univ. of Maryland 2 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Milva Berk Jacob Μ. Kleiman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Kleiman / Sister 10 Stratford Place Atlanta, Georgia 30342 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2xxCremation 3 Removal from State Kalas Crematory 10/29/2011 4 Donation 5 Other (Specify) Edgewater, Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility George P. Kalas Funeral Home PA ellen 6160 Oxon Hill Rd. Oxon Hill, Maryland uann 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physicia. disease or condition resulting in death) WIE Medical Due to (or as a consequence Examiner Secreorizily list conditions Examine if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed STRUCTIVE Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical NERTICULOS P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an r this certificate has beral director, page 2 sl autopsy perform death? 1 Tes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending Injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year) HYSILIAN 125 use of death (Item 23a) (Type, Print)

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State Registrar 7503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Yvonne Delcita Boothe Kanneh October 27 2011 9:50 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8101 Fallow Drive Montgomery Gaithersburg 5. Social Security Number 8. Date of Birth (Month, Day, May 2, 9. Birthplace (State or Foreign 6. Sex If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Min 1 M 2 X F Days 577-08-9197 53 Director Yrs Jamaica, Indies Usual Residence of Decedent 28a-f shov 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8101 Fallow Drive 20877 United States 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ntal Hygiene. ed other than "natural", or iter event, the Medical Examiner 1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Care Nurse **Nursing Services** vear Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or each 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincent Boothe Daisy Marguerite Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Awuah Kanneh (Husband) 8101 Fallow Drive; Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Brentwood, P.G. Maryland Lincoln Cemetery Ignature Funeral Serv Acans Mame and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Glioblastoma of the Brain disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): /sician . burial-Physician/Medical Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 2 Accident 3 Suicide 1 🗌 Yes 2 🗌 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical

Division of Vital s after death. completed filled in by

State Registrar

Date filed (Month, NOV O

29a. Certifier

(Check

29b. Signature and tit



Gertifying Nurse Frantionen To the best of my knowledge

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D37142

29d. Date signed (Month, Day, Year)

10-31-2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:40.4 M **JAMES** November 201 HARRY KINSEY JR Medical Facility Name (if not institution, give street and number, 4c. County of Death 4b. City Town, or Location of Death **Examiner** HARLES ATA ENTER Security Numbe Age (In yrs. last birthday) If Under 1 If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min FEB 11, 1934 1 ★ M 2 🗆 F PENNSYLVANIA 77 **Director** 209-26-8680 Usual Residence of Decedent shov 10a. State 10b. County death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD CHARLES WALDORF 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U. S. A. 5608 WAHOO COURT 20603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Decedent Ever In U.S.

Armed Forces?

1 ★ Yes 2 □ No

If Yes, Give
Year or Dates. 53 — 76 Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MATERIAL MANAGER I. Η. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H is marked of ဂ္ JAMES HARRY KINSEY SR. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. SARA CHRISTINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5608 WAHOO COURT WALDORF, JEAN A. KINSEY / SPOUSE MARYLAND 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of NOV Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) MD 16,2011 4 Donation 5 Other (Specify) VETS.CEMETERY CHELTENHAM, MD 21. Signeture of Funeral Service Licer 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. WASHINGTON AVE., LA PLATA, MD 20646 M00641 5635 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Peath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) sequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a 2 - No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **P**No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Certifica 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State,

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after dea... ral Director: Aftr filled in I 24 hours within 24 hounded the Funer completed file

only one) 3 L Certifying Nurse Practioner:	To the best of my knowledge, death	occurred at the time, date and place, and due to t	he cause(s) and manner as stated.
29b. Signature and title of certifier	ham w	29c. License number 46046	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cau	se of death (Item 23a) (Type, Print)	ennial St Suite B	La Plata Md 20646

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical

29a. Certifier

(Check

NOV 15

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy Evelyn Kraus October 24, 2011 7;15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Salisbury 1105 S. Schumaker Dr., Unit 310 Wicomico 7. Age (In yrs. last birthday) If Under 1 Year_ If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 216-10-9531 **Director** 1 🗆 M 2 🗶 F 12/27/1918 Delaware Usual Residence of Decede or 28a-f show notified at at 10a. State 10b. County with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland| Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a o the Medical Examiner must be Funeral 1105 S. Schumaker Dr., Unit 310 21804 United States mit. Page 1 and 2 should be filed within 72 hours after death artment of Health and Mental Hygiene. profant! I Ifem 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Plumbing Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bertha L. Council Luther Venard Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 S. Schumaker Dr., Unit 310, Salisbury, MD21804 John W. Kraus, Jr./ Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Lorraine Park Cemetery 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 10 27 2011 Baltimore, MD permit. F
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one. 22. Name and Address of Facility Holloway Funeral Home Professional Association 4 Chompsor CFSP Snow Hill Rd., Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death COPD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for es e nonsecuence off cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and doe detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 this certificate has performed 1 ☐ Yes 2 ☐ No Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other (Specify)} \) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 To the F 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D41721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Stephan filed (Month, Day WD 51803 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #5 Perff G922 12/06/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** ROSE MARY KENNEDY <u>11:</u>07₽ ^M 2011 11 3 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Forest Hill 213 Columbine Court 5. Social Security Number 4740 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/15/1955 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 □ F Months MD 56 215-68-47 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at Harford Forest Hill MD 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21050 213 Columbine Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married K. Kennedy Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify: White Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygin Important: If item 27 is marked other i any injury or other traumatic event, II! 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Louise Vickers John B. Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Columbine Court, Forest Hill, MD 21050 Walter H. Kennedy/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crem. 11/4/11 Leola, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licer Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or compl shock, or heart failure. List only ligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (of as a collisequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. ed by the a □Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 □ Yes 2 □ No Physician: The certificate 1 Yes 2 No After this certification and after the funeral director, r 25. Was case referre o medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending n 24 hours after death.
Ie Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi free Rd. Bel Hir, U.J. 21014 Mame and address of n who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Registrar

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VON

1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 27 Ž<u>011</u> Physician/ 6:45 AM Reginald Keenev Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Rawlings 18318 McMullen Hwy. Apt. A 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) If Under If Under 8. Date of Birth Funeral 1 □M 2 □ F Davs Hours Min. Month, Day, Ye Sep 18 Director 264-72-6299 Usual Residence of Dece "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director Rawlings MD 1 XYes 2 No Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21557 USA 18318 McMullen Hwy. Apt. A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates white Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant. If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Land Air 12 truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pauline Eichleberger unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21557 18318 McMullen Hwy. Apt. A Rawlings Sharon Keeney daughter Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Scarpelli Funeral Home, P.A. 10/28/2011 MD Cresaptown Donation 5 Other (Specify) Funeral Servic 22. Name and Address of Facility
Scarpelli Funeral Home, PA ignature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Squamous disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IE FEMALE: 23c. If yes, outcome of pregnancy
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Unknown Yes 2 No the g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2/ within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to dical Be 26. Place of Death (Check only one) 1 Yes 2 1 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier (Check ath occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, de 29b. Signature and title of certife

State Registrar

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umberland, NW 21502

of death (Item

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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an/	1. Decedent's Nam		ast)	SR.		, timoa	10 0, 2		2. Date of Dea Month OCTOBE	ath	2011	3. Time of Death 11:40 A N		
cal ner	4a. Facility Name (if	not institution, giv	e street and number)	, DIC.				Location of Deatl		4c. Cou	unty of Death	1		
	HOSPICE OF QUEEN ANNE'S CENTREVILLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of B								8. Date of Birt		JEEN A	·		
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To Be (17. Father's Name (First, Middle, Last) ANGKAMME			KES	EAROII	CHE	18. Mother's Nar	me (First, Middle, ETTA HINI	Maiden Surn	ame)	ILLINI		
	19a. Informant's Na			SOM	1	-				e Number, City or Town, State, Zip Code) QUEENSTOWN, MD 21658				
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	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 106 SHAMROCK ROAD, CHESTER, MD 21619													
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										Approximate Interval Between Onset and Death			
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Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Count	ry?						
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Physician		23a. Part I. Byter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and						
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Division of Vital Records, tal or Attending Physician: The law require rs after death. The Director: After this certificate has been sided in by the fineral director, page 2 should be a bed in the funeral director, page 2 should be a bed in the funeral director, page 2 should be a bed in the funeral director.	Set			24a. Was ar autops	y prior to co	opsy findings available empletion of cause of						
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6	Ž	29b. Signature and title of certifier	29c, License number		29d. Date signed (Mon	th, Day, Year)						
,		high, us	O.C.M.E.		October 28, 2011							
		 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimeter 	ore Street, Baltimore. MD 21	223								
Sta	ite	24 Date filed (Marth Day Vess) 29 Registrade Signature										
Registr	аг	OCT 3 1 2011 Server S. Jan										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harriette Tobin Markow October 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Min (Month, Day, Year) Days Hours 263-24-5158 92 Director 1 M 2 🔀 F 02/15/19 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other traumatic events. 10c, City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3128 Gracefield Rd. #619 20904 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes : 2 x No 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seven Up Bottling <u>Business Owner</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Abraham Tobin Rebecca Wolfenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Markow-Son Abbey Ct. Frederick, Md 21701 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Dother (Specify) King David Memorial Gardens 10/28/11 Falls Church, Va. Signature of Feneral Service License 22. Name and Address of Facility Danzansky Goldberg Memorial Chapels 1170 Rockville Pike Rockville, Md. 20852 MOO1477 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Myocardial Infarction Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine rany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, or Attending Physician: The law requires that the death certificate be executed after death. and Due to (or as a consequence of): resulting in death) Last burial physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death 2 X No be detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 \square Yes 2 \square No 3 \square Probably 4 \cancel{K} Unknown page 2 should CHF CAD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has CVA perform within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🕱 No Other: ျှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 🗆 Residence 6 🛚 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar Debrah

OCT

31 Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miller

R143201

6001 Muncaster Mill Rd Rockville, Md. 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 25 **Physician** $p^{\,\mathsf{M}}$ 2011 6:35 Glenn Gerard Marinelli, M.D /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Memorial Hosptial, 4th F1. Prince Frederick Calvert | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 01/03/1952 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Director 215-52-8055 59 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show Items 23a or 28a-f show Director 1 ☐ Yes 2 🙀 No MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2311 Shields Drive Completed by Funeral 20754 United States s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23 other traumatic event, the Model Eath, restricting the traumatic event, the Model Eath, restricting the traumatic event, the Model Eath, restricting the traumatic event, the Model Eath, restricting the traumatic event, the Model Eath, restricting the second traumatic event, the Model Eath, restricting the second traumatic event, the Model Eath and the second traumatic event, the Model Eath and the second traumatic event, the Model Eath and the second traumatic event, the Model Eath and the second traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ▼ No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Surgeon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pasquale Marinelli Louise Glennon ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jodie Marinelli / Wife 2311 Shields Drive, Dunkirk, MD 20754 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) 10/31/2011 Rockville, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee Gary J. Goff/ 8200 Jennifer Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not inter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ta STATIC denocarc uears /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death P.O. signed by the a 1 ☐ Yes 2 ☐ No 5 Other (specify) ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performe certificate Division of Vital 1 ☐ Yes 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only on examiner' Other: 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: / Accident investigation 1 ☐ Yes 2 🗌 No filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one 29b. Signature and title of certific drus eted cause of death (Item 23a) (Type, Print) M.D. 100 4051 homas 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year : 23 Della Louise MAPHIS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 252 S. Mulberry Street Washington Hagerstown Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Days Hours Min Maryland Yrs Director Ĩ938 214-42-2213 May Usual Residence of Decede 28a-f shov 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 252 S. Mulberry Street USA 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 721 al Hygiene. life. DC NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her own home other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot မ permit. Page 1 and 2 should be Department of Health and Menl Important: If item 27 is marke any injury or other traumatic to Robert L. Eaton Anna Mae Roher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Maphis - Son 128 E. Antietam Street, Hagerstown, Md. 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Fairview Cemetery 11/4/2011 4 Donation 5 Other (Specify) Keedysville, Md. Signature of Funeral Service Licenses Minnich Funeral Home 2. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year Pregnant at time of death signed by the a Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner' Other: ဥ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home After this . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider To the Hospital or Automore within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral Director of the funeral Director of Funer 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month And Year) 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Maxine Murphy 6:00 P M 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 504 Millwheel Street Capitol Heights Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 1 - M 2 5 F Director NC 579-52-6015 Jsual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Examiner must be notified Capitol Heights Yes 2 No MD Prince George's ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral United States 504 Millwheel Street 20743 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 21 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Federal Government Supervisor of Publication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie B. Minor Ollie Busbee permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Murphy/ Husband 504 Millwheel Street, Capitol Heights, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify 10/28/2011 Brentwood, Maryland Signa f Funeral Service 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, Maryland 20746 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 month Metastaic Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year Pregnant at time of death 2 🔀 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? After this certificate 1 Yes Yes 2 😾 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Tyes 2 Accident 2 🗌 No Investigation Could not be 24 hours after deatl Funeral Director; Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ayanna Beard, M.D. 5100 Auth Way, Suitland, MD 20747 31. Date filed (Month State NOV 0 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 29th 2011 2:00 Middleton Sallie K. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Director 1 🗌 M 2 🔀 F 577-44-3396 6-05-1929 Virginia 82 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 23a or 28a-f 1 XYes 2 No Md. P.G. Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 20735 U.S.A. "natural", or items 23: 9607 Tellico Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force: Black, White, etc. 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Black 3 X Widowed 4 Divorced alth and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Haley Callands Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9607 Tellico Place, Clinton, Maryland 20735 Irwin Franks - Son Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Riverdale, Maryland Riverdale Pk Crematory 11-3-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home of Funeral Service License 10583 Middleport Lane, White Plains, Md. 20695 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CARdiopulmonary Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Hypotension hours Secus tally 1st conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the de th certificate be executed burial-trar that initiated events Due to (or as a consequence of resulting in death) Last ttending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 the as 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease Kidney 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Coagulapathy Sepsis Syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2x No Yes 2 No 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Medical Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0052865 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.M. FIGAR 12150 Annapolis Ste Zoo Glenn Dale 20769 NOV 0 2 2011 31. Date filed (Month. 32. Registar's Signal State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ WANDA LEE MINER NÖVEMBER® 6 2011 12:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3774 OLD WASHINGTON ROAD WALDORF CHARLES Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth . Age (In yrs. last birthday **Funeral** Days Hours 1th, Day, 1 1 - M 2 413-62-7293 Vrs Director **7**3 TENNESSE AUG. 1938 Usual Residence of Decedent 28a-f shov death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 ☐ Yes 2 🔀 No CHARLES MD WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 3774 OLD WASHINGTON ROAD 20602 U. S. A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black White, etc. ō þ 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify. "natural" 3 Widowed 4 Divorced Specify: WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STATISTICAL CENSUS BUREAU EXAMINER permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ပ္ LEITUS BLAZER MARIE SOLOMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OLD WASHINGTON RD., WALDORF, MD 20602 ROBERT P. MINER, SR. / SPOUSE 3774 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NOVEMBER cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY MEM.GRDNS. 10,2011 WALDORF, MD Donation 5 Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? ours after death.

eral Director: After this certificate Filled in by the funeral director, page 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Man er of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural ccident work?
1 Yes 5 Pending 2 🗌 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

State Registrar

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of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ JAMES EDWARD MONN NOV.8 2011 7:44A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6176 HUMPBACK WHALE WALDORF CHARLES Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year 92 579-18-1136 **Director** 10-31-1919 WASH Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland or items 23a or 28a-f sho miner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits WALDORF MD. CHARLES 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6176 HUMPBACK WHALE CT. 20603 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 ☐ No If Yes, Give NAVY 1 Yes 2 No Specify. "natural", Completed 3 → Widowed 4 □ Divorced Specify: WHITE IIWW Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) U.S.GOVT. ELECTRICIAN 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ JAMES GARFIELD MONN IONA B. MUNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tra TIMOTHY MONN-SON 6176 HUMPBACK WHALE CT. 20603 WALDORF, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD.VETERANS CEM. Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-16-11 CHELTENHAM, MD. 21, Signature of Faneral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Medical ALZHEI disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an s certificate has the lirector, page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MD 3885 2011 30. Name and address of person who completed cause of death (Itom 23a) (Type, Print) MAMANA >0 20602 State

DHMH 17 Rev 7/2009

Registrar

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $10^{\rm Month}$ Physician/ 26 2011 1:15 Sharyn Martha Nelson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Charles 2488 Hanover Court Waldorf Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 M 2 X F Months Hours (Month, Day, Year) Feb. 4.1947 Director 212 - 54 - 341264 Washington DC Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Charles Waldorf 1 Yes 2 X No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b Funeral 2488 Hanover Court 20601 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 XXNo
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify Completed 3 Divorced 4 Divorced Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sanitation Secretary Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once. should be file hand Mental H ည Geraldine Springman Fred Albert Ruleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2488 Hanover Court, Waldorf, MD 20601 Raymond R. Nelson - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lee Crematory Nov. 2,2011 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P. A. Signalure I Funda Service License Marini Awanda 8200 Jennifer Lane, Owings, MD 20736 😘 Part 1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ovarian Onset and Death Physician/ Cancer yeah Medical resulting in death) Due to (or as a consequence of Examiner bowel obstruction 5 ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death ed by the a detached f 9 Unknown tor: After this certificate has been signed the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 No 1 Yes ျှ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 1105,05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Harvey Katzen,

31. Date filed (Month, Day, Year)

MD

32. Registra Signature

8926 Woodyard Rd, Suite 201, Clinton, MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10/26 2011 Physician/ 722 Betty A. Neff Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Months Hours 218-36-9567 **Director** 1 □ M 2XXF 79 10/6/1932 MD Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director be notified 1 Yes ZXXNo Anne Arundel Gambrills o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o Funeral 609 Neff Rd. 21054 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or iter Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes XX No If Yes, Give 1 ☐ Yes 🛣 No Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene Secretary Anne Arundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Fitem 27 is marked or other traumatic even ပ Richard Waters Hollis Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gambrills, MD 21054 Nancy Neff 609 Neff RD. Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place, ☐ Burial XXX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/28/2011 Atlantic Crematory | Glen Burnie, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Aciclosis disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Exami use as the burial-transi taime that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month signed by the at Id be detached for Pregnant at time of death 1 Yes 2 g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, pletely filled in by 4 - Homicide determined City or Town, State) Medical 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 72606 10 mount 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H 61 10 Annapous mo 200 (me NONYEW 31. Date filed (Month, Day, Year, strar's Signature State OCT 3 1 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10/26 2011 Physician/ 855рт м Marie R. Ostiguy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21113 528 Patricia Ct. Odenton 8. Date of Birth (Month, Day, Year) 1/22/1933 . Social Security Number Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Months Hours Min. 035-22-8690 78 Director 1 M 2XXF RI Usual Residence of Decedent 28a-f shov 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Anne Arundel Odenton 1 Yes 2xxNo 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 528 Patricia Ct. 21113 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Force or þ 1 Never Married 2 Married Yes 2 XXo Baltimore, Maryland 21215-0036 White If Yes, Give 1 Yes 2 XXo Specify "natural", 3 Xidowed 4 ☐ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 Applied Physics Lab Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, n and Mental 7 is marked o မ William M. Mulcahey Anna E. McCusker .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10960 Holt Ct. Denton, MD 21629 Annie Gross Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot. Date XX Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) 11/3/11 Crownsville, MD . Signature of Funeral Serva Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ ancel disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months?
1 Yes 24 No Pregnant at time of death Month Day Year should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖊 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No 1 Yes Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2/ No Hospital: 1 Yes Other: |요 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29d. Date signed (Month, Day, Year) . License number 529 30. Name and address of persent completed cause of death (Item 23a) (Type, Print) 210 Ann. p.15 MO 21401 MIDIL 2003 al 31. Date filed (Month, Day, Year) State

Registrar

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			State of Maryland / D			ental Hygie	ene	36451
			Registrar	Certificate of Dea	atn		g. No. 4 U 1	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
	Medic	al	PRISCILLA BUCK PEARI			OCT. 2	25, 2011	1:30 P ^M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loc			4c. County of Deat	
and the second			KLINE HOSPICE HOUSE 5. Social Security Number 6. Sex 7. Age (In vrs. last birth	MT. AIF			FREDE	
	Funeral Director		1 M 2 YE		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Young)	(ear) 9. Birt	hplace (State or Foreign Intry) MAINE
146			029-26-6242 1 M 2 M 2 M 3	110.		JAN. 19,	1930]	MAINE
	and show at	ō	10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	faryli 3a-f tiffied	ect	MD. FREDERICK	FREDERICK				1 🌠 Yes 2 □ No
	or 2	۵	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	untry?
	with 23a sst b	Funeral Director	6837 BUTTONWOOD CT.	2170	13		U.S.A	
	eath tems	Ę.	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispan	nic Origin? (Spec	cify Yes or No-	14. Race - Amer	
و	ter de or il	by	1 ☐ Never Married 2 ☒ Married ☐ Armed Forces? 1 ☐ Yes 2 ☒ No	If Yes, specify Cuban, Me		Rican, etc.)	Black, White	e, etc.
9200-91212	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🏋 No Sp	oecify:		Specify: W	HITE
ည	hou natu dica	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during	n a most of workin	10	6b. Kind of Business	ndustry
7	nin 7% re. han e Me	E		life. DO NOT use retired)	g most of working	9		
	ygier ygier hert nt, th		2	HOUSEWIFE			HOME	
ב	be filed ental Hy 'ked oth ic event	To Be	17. Father's Name (First, Middle, Last)	18.		(First, Middle, Ma		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	CLINTON L. BUCK		DORI	S CORA	SANBO	RN
a Ja	should and Me is mar raumati			Mailing Address (Street and N		·		<i>'</i>
	and 2: Health tem 27 other tr			337 BUTTONWOOD				
Ö	or of			Disposition (Name of y, crematory or other place)	D	ate 20	0c. Location - City or	Town, State
	t. Page tment o tant: If ijury or			RS CREMATORY			IVERDALE,	
baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ott		21. Signature of Funeral Service Vicensee	22. Name and Address of CHAMBERS FU	Facility NERAL H	OME & CR	EMATORIUM	P.A.
	TD = 60		M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not	<u> 5801 CLEVEL</u>	AND AVE	. RIVER	DALE, MD.	20737
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P	nysician/		Onset and Deuth					
تمييده	Medical Examiner		resulting in death) Due to (or as a consequence of	Cervica			ſ	
		<u>ا</u>	Sequentially list conditions, b.					
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	and and	xar	Cause (Disease or iinjury that initiated events c	n·				
_	ate be executed oblysician and the burial-transit	dical Examiner	Todaling in death, East	·7·				
9	physi	gipe	d					
00	eatn certificat attending ph for use as th	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					
X O	ath c atten for us	ciar	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	Day Year
Ď	the g	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 🗆 Other (specify)				
	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in	n Part I.	23e. Did toba	cco use contribute to	the cause of death?
ć,	sign d be	d by				1 ☐ Yes	2 № No 3 □ Pr	robably 4 🗆 Unknown
ם פ	requ been shoul	ete				24a. Was an	24h Were aut	opsy findings available
ecords,	has ge 2	Completed				autopsy	prior to o	completion of cause of
ř	n: Ine ficate v, pag		25. Was case referred to medical	00 Fi		1 🗆 Yes 2	No 1 ☐ Yes	2 🗌 No
VICAL	siciar certif recto	Be c	examiner?	Lou	of Death (Check			40-01-
>	raldi	<u>د</u>	1 ☐ Yes 2 M No 1 ☐ Inpatient 2 ☐ ER/Out 27. Manne of Death 28a. Date of injury 28b. Til	patient 3 L DOA 4		ne 5 L Residend 8d. Describe how		HOSPICE
) = {	th. After	cate		jury Work? M 1 ☐ Yes		ou. Describe now	injury occurred	
NISION	ctor:	Certificate:	3 Suicide 6 Could not be		-	8f. Location (Stree	et and Number or Rui	ral Route Number
	after Dire		4 Homicide determined building, etc. (Specify)	,,		City or Town,		
-	To the broghtal or Attending Priystcant: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tensis.	ledical	29a. Certifier 1 1 Certifying Physician: To the best of my knowledge, do					
3	n 24 l	Med	place, and due to the d ause(s) and manner as	ause(s) and manner stated. stated.				
4	1 this is	d. Date signed (Month	, Day, Year)					
			Me m	WPY	186	6 0	ctober 2	16,2011
			30. Name and address of person who completed cause of death (Item 23a) (Ty		fludt	ud wo		
			46 B Thomas Johnson Dr, Ste Z	or Freder	nck, n	D 21	702	
	Stat	е	31. Date filed (Month, Day, Year) OCT 3 1 2011 33. Registrar's Signature	hadel.				
	Registra	r	OUISIZUII Chiana B. A	- Was				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Goldie Elizabeth PEABODY 4:30 p. 2011 October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 1416 South Potomac Street Hagerstown Social Security Number 8. Date of Birth (Month, Day, Nov • 29 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months 217-10-2549 96 Mary land 1914 Director Usual Residence of Deceden 28a-f show "natural", or items 23a or 28a-f sho 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1416 South Potomac Street 21740 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: white Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) hairdresser beauty shop 8 should be filed with and Mental Hygien 7 is marked other ti other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Daniel Lloyd Stone Margaret Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health ai Important: If item 27 is any injury or other Dana Schoppert - nephew 1560 Kitchen Orchard Rd., Falling Waters, WV 25419 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 11/7/11 Hagerstown, Maryland 4 Donation 5 Other (Specify) Signat of Funeral Sep 22. Name and Address of Facility MINNICH FUNERAL HOME holad blen 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (vi as a coi il any, leading to immediate cause. Enter Underlying Examir or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Pregnant at time of death Unknown Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🗌 Yes hours after death. Ineral Director: A 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

1 Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2. Certifying my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an tle of cert D0063718 address of person who comple d cause of death (Item 23a) (Type, Print) 11110 Medical Compus Rel., Hagerstown ml 21742 Ste 123 JW-5 Tisdale Date filed (Month) trar's Signature State

Registrar

36453

			1 - State Registrar	ertificate of l	Death		Reg. No.			
	Dhysisis	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea	th	3. Time of Death		
.lin.	Physicia Medic		MARTIN ALAN PIERSON			OCTOBER	29 ^{ay} 201	1 6:00 P M		
1	Examin	er			r Location of Death		4c. County	of Death ANNE S		
	Funeral		HOSPICE CENTER OF QUEEN ANNE'S 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	CENTRE' if Under 1 Year		8. Date of Birth		Birthplace (State or Foreign		
	Director		220-52-9143	Months Days	Hours Min.	(Month, Day	; Year)	Country)		
			Usual Residence of Decedent			MAY 19,	1954	MARYLAND		
	yland -f shc ed at	ctor	10a. State 10b. County 10c. City, Town or					10d. Inside City Limits		
	e Mar r 28a notifi	Director	MD QUEEN ANNE'S GRASON 10e. Street and Number		<u></u>			1 Yes 2X No		
	rith th			10f. Zip Code 216 :	20		10g. Citizen of V	ŕ		
	eath w	Funeral	105 OAK DRIVE 11. Marital Status 12. Was Decedent Ever in U.S. 13			ecify Yes or No-		e - American Indian,		
9	ter de , or it	by F	1 Never Married 2 Married 1 Yes 2 No	B. Was Decedent of H If Yes, specify Cuba		Rican, etc.)		k, White, etc.		
8	urs af tural" al Exa	ted	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 Yes 2 X No	Specify:		Specify:	WHITE		
21215-0036	72 ho "nat	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occup e kind of work done	during most of work	ing	16b. Kind of Bu	siness/Industry		
72	ithin ene.	Con	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired) OWNER			SANITA	TTON		
<u>0</u>	led w Hygi other ent, i	Be	17. Father's Name (First, Middle, Last)	OWNER	18. Mother's Nan	ne (First, Middle, I				
lan	d be fi denta rked tic ev	To	THOMAS E. PIERSON			NE JONES				
ary	should and N is ma			iling Address (Street				tate, Zip Code)		
Σ	ealth m 27			OAK DRIVE	, GRASONV	ILLE, M	21638	_1		
Baltimore, Maryland	e 1 ar of H _i If iter or oth		20a. Method of Disposition 20b. Place of Dis 1 X Burial 2 Cremation 3 Removal from State	position (Name of ematory or other place	ce)	Date	20c. Location -	City or Town, State		
<u>E</u>	Pag tment tant: jury c		PARK	ematory or other place MEMORIAL	11/0	5/2011	EASTO	N, MD		
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euneral Service Licensee	22 Name and Addre ELLOWS, H 06 SHAMRO	ss of Facility ELFENBEIN CK ROAD.	& NEWNA	AM FUNER	RAL HOME, P.A.		
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enable shock, or heart failure. List only one cause on each line.					Approximate Interval Between		
. Links	Physician/			IG HEN	4RT F	AILU	RE	Onset and Death		
	Medical Examiner		resulting in death) Due to (or as a consequence of):		e-more av					
		r.	Immediate Cause (Final disease or condition resulting in death) a. CON 645 5TD Due to (or as a consequence of): TSC IFEMIC b. Due to (or as a consequence of):	CARD:	DMYC	PATT	17			
	ed rsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury				/			
	xecut	Exa	that initiated events resulting in death) Last C							
0	icate be executed g physician and st the burial-transit	ical								
8760	tificate be executed ng physician and as the burial-transi	Medical	u							
	endin r use		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Ectopic pregnance	ev.		23d. Dat	e of delivery		
Box	requires that the death cert been signed by the attendir should be detached for use	Physician/	in the past 12 months? 1	Other (specify)			Moi	nth Day Year		
О	at the			underlying cause giv	ven in Part I	220 Did to	hasas liss sentri	bute to the cause of death?		
	es tha	qp	PROSTATE CANCE	ENISH FI	T Day	23e. Dig to		3 Probably 4 Vunknown		
ğ	requires been sign should b	Completed	DROGNAN- CAUCE	0		/ 24a Was a				
ŏ	has has je 2	립	PE 09 (11 12 (17/00 %)	K		24a. Was a autop: perfor	sy p	Vere autopsy findings available prior to completion of cause of leath?		
Y	ician: The certificate h rector, page		25. Was case referred to medical	26 DI	non of Dooth (Chan	1 Tyes	2 M No 1	Yes 2 No		
VIT 3	ysicia s cert direct	P B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati	Oth	er:	ome 5 Reside	HOS	PICE CENTER		
<u></u>	ig Phi ter thi		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury	y at	28d. Describe ho				
o	endin eath. or: Aff	fica	2 Accident Investigation	M 1 🗆	Yes 2 No					
NSI NSI	or Att fiter d irect in by	Certificate:	3	treet, factory, office		28f. Location (St City or Town		r or Rural Route Number,		
5	pital o	<u> 2</u>								
	Hos 24 hc Fun etely	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigation of the control of the	estigation, in my opinio	on, death occurred a	t the time, date an	d place, and due	to the cause(s) and manner stated.		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Σ	only one) 3 La Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	je, death occurred at t 29c. License				anner as stated. (Month, Day, Year)		
	il		> Ent Connek Mil) D30	D48		10/	31/11		
	ms	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type,				/ '			
	•		ERIC F. CIGANEK, MD 629 RAILROAD	AVE., CEN	TREVILLE	, MD 216	17	· · · · · · · · · · · · · · · · · · ·		
	State Registra	-	31. Date filed (Month, Day, Year) NOV - 1 201	1						
			The second of	do						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 27, 2011 00:50 A Reese Palmer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Months Days Mir Hours **Director** 577-50-4546 1 🕱 M 2 🗆 F 73 Usual Residence of Decedent April 9, 1938 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 X Yes 2 No Temple Hills Maryland Prince George's ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 3210 32nd Avenue 20748 United States items 2 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married 'natural", or 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Black er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Secondary (0-12) 12th College (1-4 or 5+) h and Mental Hygien
7 is marked other ti Parking Attendent Private Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 27 is marked er traumatic e Kidd Palmer Virginia Burch 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capitol Heights, Md. 20743 of Health 6500 Ronald Road # 201 Department of Health Important: If item 27 any injury or other to once. Jacqueline Diane Thompson -20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. Date 3 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2011 Clinton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenset Stewart Funeral Home, Inc. Status Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached been signed by should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ျှ 21 No 1 Yes 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this 27. Manyer of Death Medical Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 \square Pending 1 🗌 Yes 2 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f Media of Exp. miner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Media of Exp. miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of righting time. Procultioner: It is used of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated of the consultance of the co (Check 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

NOV O

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36455 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 6, 2011 12:54 am Elizabeth Potter Joan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Reeders Memorial Home Boonsboro If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F Months Days Hours Min. Jaffonth Pay, 1931 West try Virginia 233-48-7111 80 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director WV Morgan Berkeley Springs 1 Yes XX No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 25411 U.S.A. 1068 Fairview Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc and 2 should be filed within 72 hours after þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates ₩Widowed 4 Divorced Completed Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dowl McBee Thelma Elizabeth Householder Renzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 187 Babbling Brook Lane, Martinsburg, WV 25403 Craig A. Potter - Son Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Spontage of Disposition (Name of Spontage of Disposition (Name of Disposition (20c. Location - City or Town, State Page 1 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 11/9/2011 Berkeley Springs, 4 Donation 5 Other (Specify) Cemetery e of Funeral Service Licenses Hersie Johnson FH & Cremation Center M00522 Union St., Berkeley Springs, WV 25411-1855 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 Pregnant at time of death Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FELTYIS STADROME DIABETES 1 Yes 2 No 3 Probably 4 Onknown Completed MALLITUS TYPE I NEUTROPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 🗌 Yes 1 Yes 2 N 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes Natural 5 Pending s after death. 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0019019

Registrar DHMH 17 Rev 7/2009

State

Potter

NAME

340 Mill Street, Hagerstown, MD

NOVEMBER 7, 2011

301-739-7100

21740

-6-let MD

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NOV 1

Dr. Vasant 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month / 1828 PN Medical 4a. Facility Name (if not institution, give street and **Examiner** 4b. City, Town, or Location of Death HICONICO MediCAL 3443649 PENISSULA REGIONAL If Under 1 Year If Under 2 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Director 214-46-2563 1 🕱 M 2 🗆 F 65 March 12, 1946 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f DE Delmar Sussex 1 🗌 Yes 2 🎇 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 19940 U.S.A. 16157 Whitesville Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc. ò Ś 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 Divorced Specify Completed white Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12 pump company manufacturer traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Laura Wilkins Lawrence Perdue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 16157 Whitesville Road Delmar, DE Perdue (Wife) Patricia A. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1

Burlal 2

Cremation 3

Removal from State cemetery, crematory or other place, Crematory of Delmarva Oct. 26, 2011 Delmar, Delaware 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or col shock, or heart failure. List only ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RUPTURED ABOUMINAL AGRTICAMEURYSM disease or condition resulting in death) UNKNOWN Medical Due to (or as a consequence of **Examiner** ARTORY 7 3 YR 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ADRITC VALVE REPLACEMENT AND BYPASS 3 YRS. H/o and that initiated events resulting in death) Last burialthe attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 🗌 Unknown P.0. been signed by a should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has je 2 , page performed? Yes 2 No certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: 1 Inpatient 2 X ER/Outpatient ည Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier NO 050920

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State Registrar JOY

31. Date filed (Me

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DIVISION ST. SALISBURY

ress of person who completed cause of death (Item 23a) (Type, Print)

1405

Registrar's Signa

10-28-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 201^{Ye} 26° Jane Abell Ritmiller 7:15 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Somerford Place Frederick 5. Social Security Number 8. Date of Birth Sept. 21, 1936 If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 M 2 X F Hours 217-36-2847 75 Mary Land **Director** Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1 ₹ Yes 2 No Maryland 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 21701 306 West College Terrace 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry oe filed with...
Mental Hygiene.
'ed other than "r
't the M' (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Animal Rescue Volunteer Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ٥ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Brenda Smith Francis L. Abell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 W. College Terr., Frederick, MD 21701 J. Michael Ritmiller / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Frederick, Maryland Resthaven Crematory 4 Donation 5 Other (Specify) 21. Signature of buneral Service License 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody P.A. Frederick, MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition ementa Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death ed by the a detached f Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes partension should b Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page After this certificate 1 Yes Yes Be 25. Was case referred to medica director, 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6X Other (Specify) Assi 5 hp d 4 hours after death.

uneral Director: After this ed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated npleted f (Check within 24

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b, Signatu and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnsonde Frederick mo dito2

DHMH 17 Rev 7/2009

State Registrar HIPP

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Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🤈 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 7:43 AM Jane Waneta Rock ocrober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 0/15/1929 1 M 2 K Country)
Maryland **Director** 82 12-24-6943 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Washington <u>Hagerstown</u> 10e. Street and Number er than "natural", or items 23a or the Medical Examiner must be n 10f, Zip Code 10g. Citizen of What Country? Funeral 36 High Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 9 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Henry Mary Ellen Kreps Alder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Trina M. Barr / Daughter 1116 Moller Ave., Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 11/1/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee S. Mark Su 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ EREBRO VASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin -transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRICEATION Division of Vital Records, HYPERTENS (3) 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? WYPERLIPIDEMIA ARTERS SCLEROTIC 24a. Was an autopsy CARDIO performed? O JEAJE VASCULAR Yes 2 1 2 No 1 Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 A Natural 24 hours after death. Funeral Director; A 1 🗌 Yes 2 🗌 No filled in by the Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the F 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) a mo 71081G BCT 30,2011

State Registrar 340 MICE ST

MARCESTOWN MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

DATTA

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Slanche Kidenour October 2011 4:20 P M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Boonsboro Washington 8949 Crystal Falls Drive Social Security Number 7. Age (In yrs. last birthday) 9. Birth lace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F May 1 Months Davs Hours Min. Director Marvland 214-28-2301 80 Usual Residence of Decedent 23a or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. if item 27 is marked other than "natural", or items 23a or 28a-f shorother traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8949 Crystal Falls Drive 21713 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Nurse's Aide Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Leroy Jones Lillian Metz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2.
Department of Healt.
Important: If item 2;
any injury or other to Gerald E. Ridenour, Sr. / Son 21604 Ridenour Road Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beaver Creek Cem. 10/31/2011 Hagerstown, Maryland Signature of Foneral Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA Alle a 7606 Old National Pike Boonsboro, MD 1. Enter the disease, or compli 4 lons to a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ months Medical resulting in death) Due to (ovas a consequence of) Examiner metastasis morths Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury ears arkinson the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 nding pluse as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disease, Ovarian Cancer Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performs Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ဂ္ဂ 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide hours after death ineral Director: / Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the I 3 Decrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) R115203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara A. Spencer, CRNP 747 Northern Avenue Hagerstown MD 21742 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2011 Physician/ Month Esther Mae Robinson Oct 0110 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Community Hospital Cheverly PG 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 07-12-1923 577-32-4950 **Director** 88 South Carolina Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location with the Maryland Director DC Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 53rd Pl. SE 20019 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 'natural", Completed 3X Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Chef Dept. Of Justice Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or မ Robert Waiters Mackey Hester permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1753 A Street, SE Washington, DC Bettye Dunson/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 11-3-2011 Harmony Memorial Pk Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRonald Taylor II FH of Funeral Service, Lin 10583 Middleport Ln. White Plains, MD 20695 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed trar Due to (or as a consequence of): physician ar Physician/Medical P.O. Box 68760 the use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 XNo
9 Unknown Month Day Pregnant at time of death the ; signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Advanced End Stage Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No page 2 has 1 ☐ Yes 2 X No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 XNo မှ 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 \square Pending thin 24 hours after death.

the Funeral Director: Aft
ompletely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complete 3 only one) 29d. Date signed (Month, D 29b. Signature 29c. License numbe

State

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year Registrar

30. Name and address of pe

Kathy Brenneman

NE Washington DC 20017

ause of death (Item 23a) (Type, Print)

1160 Varnum St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Albert Richard Robinson Jr. 12:20 p ^M 2011 Oct. Medical 4c. County of Death \overrightarrow{PG} 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hyattsville St. Thomas More Nursing & Rehab If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 📉M 2 🗆 F 04-26-4 935 251-56-2764 76 South Carolina Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a State 10h County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Charles Marbury MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 20658 4470 Richard Lawrence Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X☐ No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Local 77 Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mattie Bell Cain Albert R. Robinson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 2904 Arundel Rd. #4 Mt. Rainier, MD 20712 Vicurtis Robinson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-3-2011 Washington DC Glenwood Cemetery 22. Name and Address of Facility Ronald Taylor II FH Signature/of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 P. rl 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ARTERUSCIERETIC CARDIOVARCULAR DISERSE Physician/ year as disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for sels econocquence of if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami that the death certificate be executed burial-tran Due to (or as a consequence of) resulting in death) Last ng physician a as the burial-Physician/Medical Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respiratory failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an Anoxic Sweephalopathy prior to completion of cause of death? performed? Yes 2 N 2 No Hospital or Attending Physician: The 1 Yes After this certificate Be (25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital funeral director, examiner? Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗹 Natural 24 hours ofter death. 1 Tes 2 🗌 No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) October 28 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QUEENSYURY Pol Hyattsville His 20781 DEVORE MD 4203 32. Registrar State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCT 25 Day 011 Physician/ EARL GREY RANDOLPH 3:19 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WRNMMC BETHESDA MONTGOMERY 1932 13, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** 1 X M 2 🗆 F Days Hours Min. October Virginia 227-38-7683 Yrs Director 79 Usual Residence of Deceden show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No District of Columbia Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 20011 5507 - 13th Street, N. W. United States death 12. Was Decedent Ever in U.S.
Armed Forces? US Army
1 M Yes 2 NRetired Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates. 1953/1973 1 ☐ Yes 2 X No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) entary/Seconday (0-12) College (1-4 or 5+) 12th grade Crescent Properties Property Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 Virginia Randolph Anna traumatic (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Department of Health a Important: If item 27 is any injury or other trace. 5507 - 13th Street, N.W.; Washington, D.C. 20011 Dorothy Delores Long Randolph 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov.30,2011 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Arlington, Virginia 4 Donation 5 Other (Specify) Arlington National Cemetery 22. Name and Address of Facility R. N. Horton Company Morticians, Satur of uneral Servi Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition METASTATIC LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' 2 No 1 ☐ Yes 2 💢 No 1 Tes or Attending Physician: 25. Was case referred to medica filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 💢 No s after death. 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 5 Pending X Natural work? 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral C Hospital Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | | 3 | | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 0101245449 (VA) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRNMMC

State Registrar MARYANN

31. Date filed (Month

NOV 0 1

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a per med cert G921 11/30/11 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 826 2011 10 Rvan, Jr. James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO Regional MediCAL 5,44186411 TENINSULA Year If Under Birthplace (State or Foreign Country) 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours **Director** 1 XM 2 F 167-36-1924 66 July 11,1945 Pennsylvania Usual Residence of Deced or 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Salisbury MD Wicomico 10e Street and Number 10f Zip Code 10g, Citizen of What Country? "natural", or items 23a Funeral 304 Glen Avenue Apt. M3 21804 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married 9 3altimore, Maryland 21215-0036 nours after 1 ☐ Yes 2 X No Specify. If Yes, Give White 3 ☐ Widowed 4 🔀 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 t of Health and Mental Hygiene. If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Martial Arts Karate Instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ryan, Sr. Rosemary Wainwright Regis James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris P. Parks- Sister 1642 King James Drive Pittsburg, PA 15237 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of F
Important: If ite cemetery, crematory or other place) 1 🗌 Burial 2 🕱 Cremation 3 🗎 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 10/28/2011 Delmar, Delaware Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bounds Funeral Home Salisbury, MD 21804 Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a c sequence of): Examiner ulseless electrical activity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Anoxic encephalopathy and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last /sician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the P) as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Dav Year Pregnant at time of death 1 Yes 2 L detached the g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ cardiopulmonary arrest 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown is certificate has been sidirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ✓ No Hospital ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 24 hours after death.

Funeral Director: After this etely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner To the best of my incomed at the time, date and place, and due to the cause(s) and manner stated. completely (Check within 2

To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07096 10/27 2011 ynosha Peters-Itavris, MD - Hospitalist 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E, Carroll St. Strlisbury, md. 21801 Mosha Heters - Horris onth, Day, Year) 2011 egistrar's Signatur State parks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Rheel Mariah 20:35 M Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death HICOMICO Medical ROGIONAL SALISBUYA 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** M D **Director** 1 🗆 M 2 🕱 F 28a-f show 10a. State with the Maryland 10b County 10c. City. Town or Location 10d. Inside City Limits Director notified 1 X Ves 2 No Maryland Somerset Princess Anne ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 30485 Brannigan Drive 21853 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò q 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify SpeciWhite/Black "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the n a na na n|a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental H If item 27 is marked ot r other traumatic even ၉ Tia La'Tasha Walston Jason William Rheel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30485 Brannigan Dr., Princess Anne, MD 21853 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Tia Walston/mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/2011 Oaksville Cemeterv Princess Anne, MD Donation 5 - Other (Specify) Holloway Funeral Home Professional Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ___ Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen (24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? within 24 hours after death. **To the Funeral Director**: After this certificate l 1 ☐ Yes 2 No 2 No 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes Other: 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending injury work? 2 🗌 No Investigation 6 Could not be 3 Suicide
4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title ss of person who completed cause of death (Item 23a) (Type, Print) 2/80/

Registrar
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State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joselyn Rheel Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL KIRVAICO Medical 5441 56414 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year Director 1 🗌 M 2 🗶 F ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30485 Brannigan Drive 21853 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2X No If Yes, Give "natural", or 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White/Black 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event; the 1 n a n|a n|a n a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jason William Rheel Tia La'Tasha Walston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30485 Brannigan Dr., Princess Anne, MD 21853 Tia Walston mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/2011 Oaksville Cemetery Princess Anne, MD ture of Funeral Service Licensee 22Holloway Fineral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Morrimon Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final rematur Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending abundant and that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E 31. Date filed (Month, Day, Year) 32 Registrar's Signature

M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

1/801

1 X Yes 2 No

DHMH 17 Rev 06-2011

State

Registrar

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	Physicia	an/	1. Decedent's Nam		•		Cei	tificat	e or L	Jeann	2. Date of De	Day	y Year			
,a	Medi Examir	cal	4a. Facility Name (if		street and number)	er) 4b. City, Town, or Location of Death					Octobe	4c.	County of De			
	Funeral Director		5. Social Security N 577-50-	7741		e (In yrs. Ia	ast birthday) Yrs.	If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/29/	th	Calvert th			
	faryland Ba-f show tified at	Director	Usual Residence of 10a. State MD	Decedent 10b. County Calvert	;	10c. City	y, Town or Lo	cation	***					10d. Inside City Limits 1 ☐ Yes 2 🔏 No		
	n with the h nust be no	Funeral Dii	10e. Street and Nur 430 Sta	rboard La	ine	10f. Zip Code 20657						izen of What (*			
9800	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 🔀 Married 4 🗆 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	ned Forces? I Yes 2 XNo es, Give 1			Was Decedent of Hispanic Origin? (Specify if Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ▼ No Specify:				Black, Wh	e - American Indian, ck, White, etc. : White		
1215-(thin 72 hor sne. than "nat he Medic a	Completed by	Elementary/Sec	15. Decedent's Encify only highest gra onday (0-12)	ducation ade completed) College (1-4 or t	or 5+) (Give kind life. DO N			ent's Usual Occupation ind of work done during most of working 0 NOT use retired)			1	ind of Busines	•		
Maryland 21215-0036	ild be filed wit Mental Hygie narked other atic event, th	To Be C	12 17. Father's Name (First, Middle, Last) Marvin Lee Reed				1			18. Mother's Nam Lora Ce	ne (First, Middle,	, Maiden S	•			
	2 shouth and the and the strain trains.		19a. Informant's Na Edward		_(pe, Print) on – Husba	nd	1	-	•	and Number or Rur		-				
Baltimore,	permit. Page 1 and Department of Heal Important, If item any injury or other once.		20a. Method of Disp 1 🌠 Burial 2 4 🗌 Donation		Removal from State			oln C	ther place cemet	ery 11-0	Date 04–11	Bla	densbu			
Bal	permit Depar Impor any in		21. Signature of Fu	-9.5	the			P. C). Bo	ox 600, L	usby, M	ary1		me, P. A. 657		
	hysician/ Medical		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List only o Final	olications that caused ne cause on each line a	e. Inq	Canc	er the mod	e of dyin	g, such as cardiac	or respiratory ai	rest,		Approximate Interval Between Onset and Death		
	Examiner of ansit	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or that initiated events	nmediate rlying iinjury	b. Due to (or as	a consequ	ence of):				-					
_	eath certificate be executed attending physician and for use as the burial-transit	ਲ	resulting in death) l		Due to (or as	a consequ	ence of):									
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the template of the former of the funeral director.	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic Other (sp		cy			23d. Date of c Month	delivery Day Year		
ds, P.O.	v requires that the de been signed by the should be detached		Part II. Other signif	icant conditions co	ontributing to death b	out not resu	ulting in the u	ınderlying	cause giv	ven in Part I.				to the cause of death? Probably 4 🗆 Unknown		
Division of Vital Records,	The law rec cate has bee page 2 sho	Completed by									24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to death?	autopsy findings available o completion of cause of ? es 2 No		
Vital	nysician iis certifi director,	To Be	25. Was case referre examiner? 1 Yes 2		Hospital: 1	ent 2	ER/Outpatier	nt 3 🗆 De	Othe	ace of Death (Checer: 4 Nursing H		dence 6	Other (Spe	ecify)		
ion of	al or Attending Pl s after death. I Director: After th d in by the funeral	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide	5 Pending Investigation 6 Could not be	28b. Time of injury	M 2										
Divis	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.		4 Homicide	determined	28e. Place of Inju- building, etc	c. (Specify))			d-t	City or To	vn, State)		Rural Route Number,		
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2	Medical Exami Certifying Nurs	sician: To the best of ner: On the basis of e se Practioner: To the	xamination	and/or invest	tigation, in death occu	my opinio	on, death occurred a	t the time, date	and place ne cause(s	and due to th	e cause(s) and manner state as stated.		
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			Registrar 1. Decedent's Nar	me (First, Middle, La	st)				ncate of t	Deatri	2. Date of	Reg. I Death	10.		3. Time of	Death			
и	Physicia Media		Linda	Amadeo	Saı	ı1s	_				10 Month	2	6 2	OT1	6:00	a ^M			
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and	Funeral		720 Wil 5. Social Security		ex 7. Ac	ge (In yrs. Ia	ast birthda	ay)	If Under 1 Year	Frederic	8. Date of		Calv		olace (State or	r Foreign			
	Director			<u>8- 5584</u>	□ M 2 🕱 F	56	Yrs		Months Days	Hours Min	May 20	Day, Year	55	Was	hingto	n DC			
	and show lat	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											1	10d. Inside City Limits				
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	with the 23a or		10e. Street and No.	low Way					10f. Zip Code 20678			10g.	Citizen of What Country? U.S.A.						
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9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 Wever Married 2 W Married 1 Yes 2 W No						Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No Specify:					Black, White, etc. Specify: White					
21215-0036	in 72 hou e. ian "nat Medica	mple	(Sp Elementary/Se	15. Decedent's E pecify only highest gr conday (0-12)		pleted) (Give kind of work done during most of working						16b.	Kind of Bu	isiness Ind	dustry				
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Man	should and by and by is ma			Name/Relationship (7			1	_	·	and Number or Re									
e,	and 2 Health tem 2:		Donald S 20a. Method of Dis	Sauls - Hi sposition	<u>ısband</u>	20b P			L11ow Wa ion (Name of	ay, Princ	ce Fred		k. MD Location -						
Baltimore,	Page 1 ment of tant: If i			Cremation 3 Cn 5 Other (Speci	Removal from State	, ce	emetery, o	crema LV:	tory or other pla Lanney (Cem. Oct	31, 20	11 P:	rince	Free	derick	, MD			
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Division of Vital Records,	or Atter after deg Director in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b				stree	t, factory, office			n (Street a Town, Sta		er or Rural	l Route Numb	er,			
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical	(Check	2 Medical Exam	sician: To the best of iner: On the basis of e	examination	and/or in	vestig	ation, in my opini	on, death occurred	at the time, da	te and pla	ce, and due	e to the ca	ause(s) and mai	nner stated			
	To the within To the comple	Σ	only one) 29b. Signature and		se Practioner: To the	pest of my	knowled	ge, de	ath occurred at the 29c. Licens		iace, and due to	T .	e(s) and ma Date signed						
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State

Registrar

31. Date filed (Month, Day, Year) 32. Re

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER JOSEPHINE M. SCHMID 2011 5:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death KENT HERON POINT CHESTERTOWN 9. Birthplace (State or Foreign Social Security Number last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 6. Sex 1 - M 2 F 139-07-688 Director Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chestertown 1 X Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21620 States United 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ₩Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chestartown Rd MD 21620 Keeses Cm 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility LLLOWS HELFENB O SPEER ROAD C 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CEREBROYASCULAR ACCIDENT Physician/ ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HEROSCLEROSIS 0 wea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 🗷 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work? 5 Pending n 24 hours after death.

e Funeral Director: After deted filled in by the fun 2 🗌 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 004158 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) MS 31. Date filed (Month, Day, Year) 32. Røgistrar's Signature State NOV - 1 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36469 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year A M Marquerite 10 2:57 2011 Medical 30 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Huryland Medical center 25 Baltimore Baltimore 5. Social Security Number 6. Sex Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** If Under Months Days Min (Month, Day 1 □ M 2 🗓 F Hours Director Yrs Maryland 220-74-3794 Feb Usual Residence of Decedent Show 10a. State ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21740 303 N. Jonathan Street items ? death death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates Specify: Black 1 X Yes 2 □ No Specify: Puerto Rican 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "1 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Homemaker Her own home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Mason Margaret Christine McCann ant of Health and articles.

Artant: If item 27 is realty or other tr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teague Lane, Martinsburg, W. Va. <u>Donald Roman - Son</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 \square Burial 2 $\boxed{\mathbf{X}}$ Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) cemetery, crematory or other place, Hagerstown Crematory 11/6/2011 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ stuge End disease or condition huse Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): ending physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Day Month Year Pregnant at time of death the Unknown g **S**Unknown Hospital or Attending Physician: The law requires that the P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tate has page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 🔀 No မြ 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 1 Tes 2 No ☐ Accident Investigation 6 Could not be Suicide within 24 hours after des To the Funeral Directon completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 | only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

JW-1

5

strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Britton

JUSTIN

31. Date filed (Month,

1659670214

54.

Baltinore

MD

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dolores Lorraine SHILLINGBERG 3:53 a. , 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17318 Ontario Drive Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X Hours Jan. 21 Director 215-28-6286 79 Maryland Usual Residence of Decedent , show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 17318 Ontario Drive 21740 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 2 X No Yes Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify Completed 3 K Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with n and Mental Hygien 7 is marked other th 10 avon representative cosmetics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard V. McCollam Iva L. Jenkins other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Jack Shillingberg - son 17318 Ontario Dr., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of P
Important: If ite
any injury or ot cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory 11/2/11 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland MINNICH FUNERAL HOME . Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 21740 Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, ech as cardiac or respiratory ar Approximate interval Between nset and Death Immediate Cause (Final Ph sician/ HAUN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the Unknown 9 Unknown P.O. by signed k Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 2 No Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 PNo Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 1 Natural 5 Pending work' Accident
Suicide 1 🔲 Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only ghe 29b. Signatu 2011 ath (Item 23a) (Type, 🗗 TIN-10

State Registrar 31. Date filed (Month. Day.

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** october 22, **JEAN** 2011 SEIVER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice B. Tawes Nursing Home Crisfield Somerset If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 TY Director 90 | Virginia 224-12-0698 April 3, 1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Items 23a or 28a-f show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at ty∑Yes 2 No Director Maryland Somerset Crisfield 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 201 Hall Highway 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Important: If item 27 is marked any Injury or other traumatic evonce. William H. Day Lucy Vetter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21804 19a. Informant's Name/Relationship (Type. Print) 909 Progressive Circle, Ste. 100, Salisbury, MD ce of Disposition (Name of Date 20c. Location - City or Town, State Donna Blackwell (P.R.) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 10/25/2011 Delmar, DE 22. Name and Address of Facility THOMAS FUNERAL HOME 21. Signature of Funeral Service Lisensee 700 Locust Street - Cambridge, MD 21613 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed

1 Yes 2 No certificate Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Hospital or Attending

State Registrar 29b. Signature and title of certifier

30. Name and address of pers

Mishelel, no 20817

and manner stated

who completed cause of death (Item 23a) (Type, P.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5,19a-b, per fh, g922 12-9-11 sm State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Esther Howeidy Sesay **October** 24. 2011 10:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring 1075 Ruatan Street Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 1949 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)

December 8, Months 1 M 2 X F Days Hours Kano, Nigeria Director 61 Usual Residence of Decedent show 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 X Yes 2 ☐ No Maryland Montgomery Silver Spring 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20903 United States 1075 Ruatan Street ral", or items? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc 1 Never Married 2 Married Yes 2 No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: **Black** Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Certified Nursing Assistant Nursing Homes vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howeidy **Beccles** Anthony Lucy 9a. Informant's Name/Relationship (Type: Print)
Comfort Johnson (Sister)
Lucy Kandchna Sesay (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 20904 105 Fairland Road Silver Spring, Maryland 20903 1075 Ruatan Street; Silver Spring, Maryland 20903 20a. Method of Disposition 20b. Place of Disposition (Name of Nov.5,2011 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) ø£ 4 ☐ Donation 5 ☐ Other (Specify) Heaven cemetery Silver Spring, Maryland ame and Address of Facility R. N. Horton Company Morticians, 21. Signature of Funeral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-transi and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 **X** No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at ē 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No Certifical Accident Investigation the Funeral Director; upleted filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month. Day, Year) D0064983 27, 2011 October 0

State Registrar 30. Name and adds

31. Date filed (Month, Day

Kashif

ss of person

Firozvi,

2101 Medical Park Drive; Suite 200

20902

Silver Spring, Maryland

o completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maya Sesay 3:59 Medical 26,2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Community HOspital Lanham Social Security Number 1950 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country West Africa Sierra Leone 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min 1 🗆 M 2 🗶 F Months 578-35-8395 61 **Director** Yrs January Usual Residence of Decedent show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Prince Georges Lanham 1 X Yes 2 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be with Funeral or items 23a 4518 Kinmount Road 20706 Sierra Leone, West Africa Was Deceue... Armed Forces? Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ 1 Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", **Black** Completed 3 Widowed 4 Divorced Specify: 27 is marked other than "natur traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) **12th grade** College (1-4 or 5+) Housewife Domestic Be and 2 should be filed Health and Mental Hy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bockarie Sesay Nenneh Sesay 19a Informant's Name/Relationship (Type, Print)

Maligre Sesay (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce. <u>Yainkain Kargbo (Daughter)</u> 4518 Kinmount Road; Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 11. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sierra Leone, West Africa Kissy Road Cemetery 2011 21. Signature of Funeral Ser 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 02 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate ☐ Yes 2 ☐ No Yes funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Accider 5 Pending injury work? 1 \(\text{Yes} \) 2 🗆 No Accident Investigation 6 Could not be 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 within 2. To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mas MOD 53718 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good 31. Date filed (Month, Day, Yea State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amended item #10-wchd-te-10 Destitutate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Octobe 6:00 P M Stan1ey J. Sage Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Point Marylana Ceci 8. Date of Birth 9. Birthplace (State or Foreign Country) New Jersey If Under 24 Hrs Funeral If Under 1 Year 1 💢 M 2 🗆 F 0172071930 158-20-1185 **Director** Yrs Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No DE Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 19958 34243 Beech Drive -19968 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ permit. Page 1 and 2 should be filed within 72 hours after of Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir X Yes 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1953/54 *\alphage, 5tan ley \ose* Baltimore, Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Worker U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rose Cherubin Joseph Sajewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winding Way, Mt. Holly, NJ 08060 Gail A. Kelly / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State DE Veterans X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🗖 Donation 5 🔲 Other (Specify) Millsboro, DE 10/28/2011 Memorial Cemetery 21. Signature of Fundal Service Censes 22. Name and Address of Facility Parsell Funeral Homes & Crematorium 16961 Kings Highway, Lewes, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other ဥ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medica 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Point, Shandelva 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 0 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Year RUTH BOUTWELL SUITE NOV. 6, 2011 10:30AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST. MARY'S HOSPITAL ST.MARY'S LEONARDTOWN If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours WASH. Director 577-40-8251 81 Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. PRINCE GEORGES CLINTON 1 Yes 2 XNo 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 6906 CRAFTON LANE 20735 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mea PICTURE RESTORATION & FRAMING GOLD LEAF SHOP Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NORMAN GRIFFIN HANCY MAY BOUTWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MATTHEW SUITE-SPOUSE 6906 CRAFTON LN. CLINTON, MD. 20735 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State METROPOLITAN CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 11-7-11 ALEX., VA. Signature Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNÉRAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical months Examiner Sequentially list conditions, if any, leading to immediate caece. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O, Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 34198 11/6/11

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ed

31. Date filed (Month, Day, Year) NOV 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hage rear | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) theran avenuoca Lu Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 1 1 198-01-6172 100 **Director** 11 1911 Antrim TWP, Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 28a-f show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Modical Examinar must be recitited at Director X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1183 Luther Dr. 21740 US Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any Injury or other traumatic event 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) teacher public school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 L.Roy Pensinger Mary E. Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Lee Diehl 159 Pensinger Rd. Greencastle, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 11/9/2011 4 ☐ Donation 5 ☐ Other (Specify) Greencastle, PA 21. Signature of Fun of Service Licenses 22. Name and Address of Facility Miller-Bowersox Funeral Home 521 S. Washington St. Greencastle, PA 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 84eas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if one lied ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) ed by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XXNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 🗆 No hin 24 hours after deatl the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) an 028365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rull flut Haystemmo 2790

Registrar DHMH 17 Rev 1/2001

State

368

SHARDS

32. Registrar Signature

(Month, Day, Year)

1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 1 1 3 6 1 7 7												
			Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death									45	14 1
	Physicia Medi		Herman Leon Tucker							, 201 ^{Year}	3. Time of 6:30	A M	
	Examin	ner	4a. Facility Name (if not institution, give street and number)		4b. City, T		Location of			40	. County of Dea		
	£		4911 Ridge Crest Court				derio				Frede		
Funeral Director 5. Social Security Number 280-26-5750 6. Sex 1. 28 M 2 F 7. Age (In yrs. last birthday) 80 Yrs.						1 Year Days	If Under 2 Hours		8. Date of Birt Feb. 28	9. Birthplace (State or Foreign West Virginia			
	, A	1.	Usual Residence of Decedent										
	yland f sh ed al	탾	10a. State 10b. County 10c. City, To									10d. Inside Ci	
	Mar 28a notifi	į	Maryland Frederick 10e. Street and Number	F	reder							1 Ll Yes	2 🛣 No
	th th	Funeral Director			10f. Zip				1		tizen of What Co	1	
	ms 2	an a	4911 Ridge Crest Court	40.)		1702		1-0-(0	16.24	Į.	Jnited S		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13 ☒ Yes 2 □ No If Yes, Give Korean Wayear or Dates.	l If	Yes Decede Yes, specif	fy Cuban	, Mexican,	in? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit Specify: Whi	e, etc.	
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2	with ygien her ti			Comm	unica	tion	s Spe	ecial	ist	Fee	deral Go	overnmer	ıt
Maryland	ld be filed Mental Hy arked ott	17. Father's Name (First, Middle, Last) (unk.) 18. Mother's Name (First, Middle, Maiden Sun Lalah Tucker							Surname)				
	nd 2 shoul ealth and n 27 is m										Town, State, Zi		
altimore,	ge 1 ar nt of He : If iter or oth		1 Burial 2 X Cremation 3 Removal from State ceme	tery, crem	sition (Name	her place,) 00	ct. 20]	<u>†</u>		ocation - City or		
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			23a. Pa 1. Enter 1. disease, o con plications that caused the death, Do shock, or he in failure. List only one cause on each line.	not ente	r the mode	of dying,	such as c	ardiac or i	respiratory arr	est,		Approximat Interval Bet	ween
Physician/ Medical Examiner Immediate Cause (Final disease or condition resulting in death) Progressive Supranuclear Palsy Due to (or as a consequence of):										5 year	Death 'S		
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Hypothyroldism 24a. Was an 24b. Wer autopsy performed? 1								death?	Yes 2 No				
ita	siciar certif recto	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpution: 2 Dept.			Other	e of Death	(Check o	nly one)				
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Θ	nital or urs afte ral Dir lled in		bullaing, etc. (Specify)						City or Tow				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my knowledge	or investig	gation, in my	y opinion,	death occ	curred at th	ne time, date ar	nd place	, and due to the	cause(s) and ma	nner stated.
_	To t To t		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
۹			Dog189 10/27/11										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, M.D. 300 West 9th Street, Frederick, MD 21701													
			Austin Pearre, M.D. 300 West 9th 31. Date filed (Month, Day, Year) 32. Megistrar's Signature	Str	eet,	Fred	erick	c, MD	21/01				
	Stat Registra	-	OCT 28 2011	100	akal								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Archie William Talbert october 2:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St Agnes Hospital Baltimere, MD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours Country) 08-19-1940 Director 224-50-3086 S.C. Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 🗆 Yes 2 🔀 No S.C. Greenwood Greenwood ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1010 Grace St., 29649 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Jral", or iter Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Private ge 1 and 2 should be filed with tof Health and Mental Hygie; If item 27 is marked other or other traumatic event, the 12th Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Luther Talbert Annie Williams Martin Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Talbert - Wife 1010 Grace St., #12D Greenwood, S.C. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 11-5-2011 Baltimore, Maryland Carmel Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Moers Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Md. 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final bronchopneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ Unknown Unknown signed by 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 \square No 3 \square Probably 4 $ot \Sigma$ Unknown certificate has been 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of prior acute my ocardia performed Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: 1 🗌 Yes 2 XNo ြု 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural (Month, Day, Year) 5 Pending 1 Tes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Selbe M.D

State Registrar 31. Date filed (Month, Day, Year) NOV 0 2 2011

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32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36479 Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Mary T. Trainum 2011 12:50 A M October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 619 Crawfords Ridge Rd. 0denton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 1 F Months (Month, Day, Year 10/4/195 Washington, DC **Director** 60 216-58-7019 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md Anne Arundel Odenton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 619 Crawfords Ridge Rd 21113 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FERC - Federal Gov't 4 <u>Human Resources Specialist</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Martin Ronan Bridget Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Crawfords Ridge Rd. Odenton, Md Lawrence Trainum 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o cemetery, crematory or other place, ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 11/3/11 Brentwood, Md 21. Signature of Fune at Secretary ce Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home naxus 20722 B401 Bladensburg Rd Brentwood, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Corticobasal Degeneration years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or illijury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the atter atten 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hyperlipidemia Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an History of Thyroid Cancer autopsy 2 X No 1 Yes 2 No 1 Yes ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🕱 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Na Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined hours Funeral Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted 24 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 20 D36091 October 31, 2011 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State

Registrar

DHMH 17 Rev 7/2009

Anthony Boakye

MD

888

Annapolis, Md 21401

Restgate Rd

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Baltimore,	t. Page tment c tant: If ijury or					30 11_1 10_				DO Md.					
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only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due 29b. Signature and title of certifier 29c. License number HY77 49 4															
	413		20. Name and address of nerson who campleted source of death //tem	23a) (Type, Pr	sim th										
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Please Type or Print in Black Indelible Ink. Frsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar 36481 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15:33 M Wallace Clayton Vincent, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medicul Center Wicomico Date of Birth Birthplace (State or Foreign Country) **Funeral** Month (Month, Day, Year) **X** M 2 □ F Director 214-07-8716 04/17/1920 91 MD Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Pocomoke City 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2123 By Pass Rd. 21851 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Forces? by Black, White, etc. 1 Never Married 2 Married 1X Yes 2 No
If Yes, Give 1.940-1945
Year or Date 1.940-1945 Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electric Company Lineman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sallie Taylor Wallace C. Vincent, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeri Vincent/Daughter 2123 By Pass Rd., Pocomoke City, MD, 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Bethany Methodist Cem 11/04/2011 Pocomoke City, MD Signature of Furfal Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. 107 Vine St., Pocomoke City, MD,21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ Tue th (or as a consequence disease or condition resulting in death) Medical Examiner Aspiration Pneumonia Sequentially list conditions Due to (or as a dui sequence of, if any leading to trained cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Id be detached for use as the buria Physician/Medical that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown neec 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? After this certificate 1 🗌 Yes 2 🗔 1 Tes 2 No Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certific Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 Yes ER/Outpatient 3 DOA 1 Dopatient 2 -4 Nursing Home 5 Residence 6 Other (Specify) apletely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Proutitionars to the course of the cause (s) and course of the cause (s) and course of the cause (s) and manner stated Certifying Nurse Proutitionars to the cause (s) and manner as obtained at the time. Cate and place, and due to the cause (s) and manner as obtained at the time. (Check within 2 only on 29b. Signature 29c. License number 10/27/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Motaz Baibars. m. D. P.R. m. C. 100 E. Carroll St Salisbury, md. 21801 31. Date filed (Month, Bay, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Sharon Simona Willig 25°. 201T 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death College View Center Frederick Frederick 5. Social Security Number If Under 1 Year I if Under 24 Hrs. 8. Date of Birth Aug. 3, 1952 **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 □ M 2 🖾 F 214-62-6032 Director 59 Maryland Usual Residence of Decedent 28a-f shov with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified 1 X Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number o 10g. Citizen of What Country? Funeral 23a 1323 Hampshire Drive 21702 United States "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: White Completed 3 🛮 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Schifflett Margaret Strickler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin L. Willig IV / Son 1323 Hampshire Dr., Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Resthaven Crematory Frederick, Maryland 2011 Signature Uneral Service Licenses Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 Enter the diseas complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or beart failure ist only one cause on each line Onset and Death Physician. etastatic disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury Lue to force a consequence by attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been si Completed 1 Yes 2 No 3 Probably Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perforn 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 \square Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 [3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-26-2011. MD and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MDZ1702 temen

State

Registrar

31. Date filed (Month, Day, Year)

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G927 5/31/2012 JH State, of Maryland ... Department of Health and Mental Hygiene Department of Health and Mental Hygiene 1928 0/25 2012 Certificate of Death Beg. No. State
Registrar 36483 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joan Marie Williams -Guider 10 727/2011 ay 9:46 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10301 Iron Gate Ct. Ocean City Worcester 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign MD Country) 1 M 2 XF Hours **Director** 219 46 65 9/9/1946^{ear)} Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Worcester Ocean City 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10301 Iron Gate Ct. 21842 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Completed white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) executive secretary Federal Gov. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John R. Williams Grace Lanham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Hance (sister) 24802 Rivers Edge Rd. Millsboro, DE 19966 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 1st State Crematory 10/28/2011 Millsboro, DE 5 Other (Specify) 21. Signature of Fu 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition moneration Conces Medical resulting in death) Due to (or as a consequence of) *Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 88 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

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Unknown detached for Month Dav Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it 1 Yes 2 No completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 2 No Certificate: To 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BA 20 State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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1); ()

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H44828

28/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death walls Physician/ Month F Betty 10:33AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2504 Amber Orchard Ct.W Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 11/17/1928 234-40-8223 **Director** 1 □ M 2 🗶 F 82 WV Usual Residence of Deced 28a-f show with the Maryland 10a. State 10b County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits MD Anne Arundel 1 🗌 Yes 2 💢 No Odenton 10e, Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2504 Amber Orchard Ct. W 21113 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. "natural", or iten edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Child Care Child Care Be 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Barnett Effie Garlick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Lister (daughter) 2504 Amber Orchard Ct. W. Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 \square Removal from State Gracelawn Memorial Pk 10/31/2011 4 ☐ Donation 5 ☐ Other (Specify) New Castel, DE Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Atheros depotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Dise to for as a non-mounter of that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ Month Day Year signed by the at Id be detached for Pregnant at time of death 1 ☐ Yes 2 b 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform Director: After this certificate 2 🗌 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death Accident Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral [Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MsRijapalne M.O D0057465 10127/11

State

Registrar

2835

5-203

Baltimore

MD 21709

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

· Kajapakse, M.D

OCT 3 1 2011

N-5

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANICE ELLEN WAGNER OCTOBER 2011 9:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **QUEENSTOWN** QUEEN ANNE'S **404 COVE ROAD** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 136-36-0856 **Director** 1 □ M 2 🗶 F 68 11/15/1942 **MARYLAND** Usual Residence of Deced 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f QUEEN ANNE'S QUEENSTOWN MD 1 Tes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a UNITED STATES 404 COVE ROAD 21658 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fatter 17 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mun or other traumatic event, the Medical Examiner mun or other traumatic event, the Medical Examiner mun or other traumatic event, the Medical Examiner munical manual or other traumatic event. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: WHITE Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 OFFICE COORDINATOR **MARINA** Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ RONALD GOUKER MARGARET WORRELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN F. WAGNER / HUSBAND 404 COVE ROAD, QUEENSTOWN, MD 21658 20a. Method of Disposition 20b Place of Disposition (Name of Department of H Important: If ite any injury or other 20c. Location - City or Town, State CHESAPEAKE CREMATION
CENTER 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/01/2011 STEVENSVILLE, MD 21. Signature of Funeral Service Ligenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Un a cancer disease or condition Months Medical resulting in death) Due to (or as onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin burial-transi that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the at be detached for 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown should Completed been Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? 1 Yes 2 No Yes 2 X No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending injury s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a

To the Funeral C To the Hospital cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31/ 2011 Ter pero MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

oursevalle Dr.

Centreville,

202

Malaro

Margaret D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dentis Name (First, Middle, Last) 2. Date of Death Physician/ Month 9830AM , 2011 Medical **Examiner** or Location of Death annan **Funeral** last birthday If Under 8. Date of Birth 9. Birthplace (State or Foreign 507-18 1 M 2 D F Months Director Nebraska 28a-f shov is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Page 1 and 2 should be filed within 72 hours after 21215-0036 1 Yes No If Yes, Give 1 🗆 Yes 2 📉 No 3 - Widowed 4 - Divorced Specify Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland Father's Name (First, Middle, Last) ည injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) in ite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) atha amison Baltimore, 20a. Method of Disposition permit. Page 1 s
Department of H
Important: If ite
any injury or ot 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Rivendale Kiverdalell 11-1-2011 Signature of Juneral Service WISEMEN 7531 texandrus terry Rel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastatic Physician/ Onset and Death Pancreatic cancer disease or condition resulting in death) Medical Examiner patic Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury Hypovolenie that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-PS15 Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 g Unknown Pregnant at time of death Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? After this certificate has been si funeral director, page 2 should ¹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No မ npatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 2 🗌 No Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number

Dovo 52157 29d. Date signed (Month, Day, Year) Abelee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMARE ABEBE 8118 Good Luck Rd, Lanham MD 20706 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Stewart Wootten Sr. 201[°]Î 3:17 P M October 26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury Wicomico Nursing Home 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Security Numbe **Funeral** 1 🛛 M 2 🗆 F Days Hours Months 215-26-4387 0970271931 Maryland Director 80 Yrs Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice." 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 614 Douglas Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Navy 1 ☐ Yes 2 K No Specify: Specify: 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Welding Supply Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Victor L. Wootten Winnie E. Nock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 Douglas Rd., Salisbury, MD 21801 Elizabeth Wootten/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Salisbury Crematory 10/27/2010 Salisbury, MD 4 Donation 5 Other (Special Signature of Funeral Service Li Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner trany leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the s should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 🗓 25. Was case referred to predical funeral director, 26. Place of Death Check only one Be examiner? Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Medical 29a. Certifier 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

Mahesha

31. Date filed (Month, Day, Year)

Easternshore Dr Salisbury MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thimmarayappa

MD

32. Regisar's Signature

Ple	ease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible	e.			
	State of Maryland / Department of Health and Mental Hygiene	001	P.	364	0
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		1- For State Registrar	Certificate of Death Reg. No.							1	1 3040				
	Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death								Voor		3. Time of Death				
Medical Exam	ical Examiner BARBARA ANN WOOD November 3, 2011							Year 11		1215 hrs					
		4a. Facility Name (if not institution 8595 Neptune Lane	n, give street and n	treet and number) 4b. City, Town, or Location of Deat Bel Alton				of Death	4c. County of Dea Charles			Death			
Funeral		5. Social Security Number	Number 6. Sex 7. Age (In yrs last birth									D/YYYY)	9. Birth	nplace (State or	
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		218-80-6323 Usual Residence of Decedent	1 M 2XXF	₹ 52 Yrs.				SER.7,1959 C				MD			
any		10a, State 10b, County		10c. City	Town	r Locatio	n						$\neg \tau$	10d. Inside City Limits	
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eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Funeral	11. Marital Status		cedent Ever in U	.S.					ecify Yes or N	0- 1	14. Race White,		an Indian, Black,	
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Hyg d oth		17. Father's Name (First, Middle, I	· ·					18.Mothe	ers Name	(First, Middle,	Maiden S	urname)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be	JAMES L. SM			1.00	NA - 111		MA	RY I	OUISE	WII	JLS			
D 2 shoul and N	ĭ	19a. Informant's Name/Relationsh								ural Route Nu					
MD and 2 sho alth and 2 is raumati		LEWIS L. WOO:	D / SPO		7(070	STRIN on (Name of	GER	PL.,	Bryan	s Ro	AD, I	4D_	20616	
ore, sla of He If ite		1 X Burial 2 Cremation	3 Removal fi	om State	cremato	ry or othe	r place)		NOV	EMBER	200. LC	xalion - C	ity or i	own, state	
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Baltimore, MD 2121(Dermit. Pages I and 2 should be fill Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, t		21 Signature of Funeral Services Licensine 22. Name and Address of Facility RAYMOND FUNL SERV.									RVI	CE.P.A.			
E E A B CO		for so	7 200	MO(0641	56	35 WA	SHIN	GTON	AVE.	, LA	PLAT	ΓA,	MD 20646	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 0641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Approximate Interval Between Onset and													
`/Medical ≟xaminer		Immediate Cause (Final disease a. Drowning Between Onset and Death													
or condition resulting in death) Due to (or as a consequence of);															
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		23b. Was decedent pregnant in the past 12 months?	1 Live	oirth	2	Fetal	death	Ectop	ic pregnar	ncy	N	J onth	Day Year		
Box 687 e death certific the attending ged for use as the	Sici	1 Yes 2 No 9 V Unkr		nant at time of de	ath 5	Othe	r (Specify)								
he de y the	Physicia	Part II. Other significant condition	9 UIKII		an diina	in the	doskrina nava	airea ia D		230 Did	obassa us	no contribu	ito to th	ne cause of death?	
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Vita ysici direc	.0	examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpatient 2	ER/Out	patient	3 DDA	Other ₄	Nursing	Home 5	Residence	ce 6 🗸	Other:	Scene	
ing Ph After t uneral	⊢	27. Manner of Death	28a. Date	of Injury , Day,Year)	28b. Ti	me of Inju	ıry 28c. In	jury at Wor		28d. Describe				1 - 1 - 1	
On Sath.	텵	1 Natural 5 Pendir	ng Eal 1		fd 1	2:15	am 1	Yes 2 🗶				.1 1n1	to 1	large body	
Pending Investigation Fd 11-3-11 Fd 12:15 am 1 Yes 2 No Of water 2 Xes Accident 3 Suicide 5 Pending Investigation 6 Could not be determined Copecify Large body of water 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 859 Rel Air, Md. 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.							d Number	Number or Rural Route Number, City							
pital o	The state of injury at work? 2 2 2 2 2 2 2 2 2								:ptu	ne Lane					
Hosp 24 ho Func tely fi	calC	29a. Certifier 1 Certifying Phy	sician; To the bes						ace, and	due to the cau	se(s) and	manner as			
To the Hos within 24 h To the Fur completely	edic	one) 2 Medicai Exam	aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								cause(s)				
E 3 E 8	₹	29b. Signature and title of certifier	o marmor s				29c. Lice	nse number			29d. Da	ate signed	(Mont	h, Day, Year)	
		temph Govetho	el, mi				0.0	C.M.E.			Nove	mber 4,	2011	1	
	ŀ	30. Name and address of person w		se of death (Item	23a)										
	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223														
St	ate	31. Date filed (Month, Day Year)	2011 32.	egistrar's Signatu	ire	bar	les.								
Regist	trar	MUATO	2011	neva 1	13. 1	a wo			_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Deat Physician/ BARBARA Month / WILLIAMS 0045 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Harwood Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 578--56-6674
Usual Residence of Decedent Director 1 - M 2 F 69 April 21,1942 Wash., DC 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No MD PG Upper Marlboro ö 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral 8951 Town Center Circle #209 20774 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Specify. Completed Year or Dates Black Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the 4 School Teacher PA Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is markec Unk. Vivian Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 B Street, SE #T022 Washington, DC 20019 Paula Williams/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/9711 injury or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Suitland, MD Washington Nat. Cemetery f Funeral Service Licensee any in 21. Sign Jure 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be represented in the cause on each line. Approximate B Immediate Cause (Final Monset and Death Ph_ysician REAS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? be detached for Month Day Year Pregnant at time of death 2 No g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 1 Yes Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 6 Other Special Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 4 hours after death uneral Director: / 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a To the Funeral I Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature and title

Name and address of pe

ICHAEL 31. Date filed (Month, Day, Year)

of certifier

447DEFENSE

a w

pholeted cause of death (Item 23a) (Type, Print)

32

29c. License number

V1438

NNAPOLI) MD21407

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physician/ Medical Examiner **Funeral** Director "natural", or items 23a or 28a-f show edical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director Funeral þ Baltimore, Maryland 21215-0036 Completed event, the Medical is marked other than Be 2 other traumatic permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Physician/ Medical Examiner Examine attending physician and for use as the burial-transi by Physician/Medical

State Registrar

 $10^{
m Month}$ 23^{Day} 20^{Yea} Richard G Wright P M 2:25 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1004 Riverhouse Drive, Apt. Salisbury Wicomico 7. Age (In vrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Yea -23-1929 Pennsylvania 213-24-1511 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Riverhouse Drive, 21801 Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Drywall/Painting Co. Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Wright Flossie Jean Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Wright - Wife 1004 Riverhouse Drive, Apt. Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 N Other (Specify) Entombment Wicomico Memorial PK 10-29-2011 Salisbury, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Bounds Funeral Home Main Street. Salisbury, Maryland 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List one one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE 13 yrs ONGESTIVE HEART PAILURE MONTH S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury MNTG the Hospital or Attending Physician: The law requires that the death certificate be executed NEWMONIA that initiated events resulting in death) Last MONTHS RENAL CANCER Division of Vital Records, P.O. Box 68760 es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Id be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed No 1 Yes 2 No 25. Was case referred, to medical 26. Place of Death (Check only one) the funeral director, Be examiner? 2 🗹 No Hospital Other: ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this o 28a. Date of injury (Month, Day, Year) 27. May er of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred **√** Natural 5 \square Pending 2 🗆 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 050929 10-24-11 TO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADARANG-LEWIS SAUSBURY MO 21804 1405 S. DIVISION 31. Date filed (Month, Day, 32. Begistrar's Signature State 6 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36491 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 21, Physician/ Howard Glenn Wolfe 201^{rear} 7:40 **A.** M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fréderick Mt. Airy Kline Hospice House 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 ☑ M 2 ☐ F Hours 79 July Day Jear) 1932 Mary land 217-28-6262 Director Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits with the Maryland Completed by Funeral Director Smi thsburg Frederick Maryland 1 🗆 Yes 2 🗀 No 10e. Street and Number 14341 Pleasant Valley Rd. 10f. Zip Code 10g. Citizen of What Country? 21783 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. X ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Carpenter" Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Parker S. Wolfe Ethel M. Kuhn 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14345 Pleasant Valley Rd. Smithsburg, Md. 21783 Annette Wivell (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 24, Pleasantrowaliebraten. Smithsburg, Md. Signature of Funeral Service License 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph. sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year ed by the a detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl performed? Yes 2 I ☐ Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined ☐ Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check

Registrar DHMH 17 Rev 7/2009

State

only one

29b. Signature and title of certifier

Eric Bush MD

31. Date filed *(Month, Day, Year)* **NOV 1 5 2011**

an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trail

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

reder

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 25, 2011 6:21 а м Maggie Elizabeth Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4321 Sixes Road Calvert Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗷 F Days Hours Month, Day, June 26. MD **Director** 218-34-6439 90 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince Frederick Calvert 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20678 USA 4321 Sixes Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 ™ Never Married 2 ☐ Married Completed by 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Domestic** Someone Else's Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alexander Young Ozella Height 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 744, Prince Frederick, MD 20678 Beatrice M. Young - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Western Cemetery October 29, 2011 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State Prince Frederick, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licenson 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) rears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence or): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 1 Yes 2 D 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No Hospital

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 To the Funeral Director: After this certifica completed filled in by the funeral director, p

1 🗌 Yes

27. Manner of Death

1 Natural

Accident
Suicide

4 Homicide

29a. Certifier

(Check

5 Pending

ATEL

Investigation 6 Could not be

determined

ျပ

Certificate:

Medical

EN State 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28c. Injury at

D005906

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28d. Describe how injury occurred

City or Town, State)

ince frederick MD 20678

28f. Location (Street and Number or Rural Route Number,

October 27, 2011

28a. Date of injury (Month, Day, Year)

MD

110 Hospital

32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear Physician/ 10134 Isabel Yingling 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 11, 1922 Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Mary Land 215-18-1738 89 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1√2 Yes 2 □ No 28a-f Maryland Washington Boonsboro 10e. Street and Number 10g. Citizen of What Country? ŏ ms 23a or must be r Funeral 417 North Main Street 21713 USA items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 M Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Associate 12 traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Fllen DeLawter Sarah Brandenburg Albert Oscar 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy L. Green/daughter Health a O. Box 664, Smithsburg, Maryland 21783 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal/Imporm State cemetery, crematory or other place) Wolfsville, Maryland St. Mark's Lutheran Nov.4, 2011 5 🖵 Other (Specify, 4 Donation 504 Main Street 22. Name and Address of Facility Myersville, MD 21773 Ricketts Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition STAGE Ph_sician/ END I week Medical resulting in death) Due to (or as a consequence of): Examiner WEERI DOSTIDITUE CHRONEC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): PALLI STIVE burial-transit CMIL Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the af d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 D No 24a. Was an autopsy performed? Yes 2 No has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\subseteq \text{Yes} Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 2 🗆 No 1 Yes Investigation Accident Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 7/2009

State

Registrar

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAOIR

29b. Signature and title of certifier

GHMMA

NOV 15

31. Date filed (Month, Day, Year)

LATTANS

29d. Date signed (Month, Day, Year)

BOONSAOND

(DAD

11-08231 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ta'miah Ta'jiah Armstrong State of Maryland / Department of Health and Mental Hygiene 36494 2011 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 3, 2011 0931 hrs Medical Examiner Ta'miah Ta'jiah Armstrong 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death University Hospital **Raltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Director Country) Maryland 2X F 1 M May 07,2011 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c, City, Town or Location 10b County 1 XYes 2 No items 23a or 28a-f show Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
isjury or other trannatic event, the Medical Examiner must be notified at once Baltimore rector Marvland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ā USA 21217 1365 N. Gilmor Street Funeral 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lakierra Bailey Brandon Armstrong
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1365 N. Gilmor Street Baltimore, MD 21217 <u> Lakierra Bailey/ Mother</u> 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Arbutus Memorial Park 11-11-2011 Arbutus, Maryland Donation 5 Other S fy 22. Name and Address of Facility Chatman-Harris Funeral Tome 21. Signature of Funeral Servi et icensee 5240 Reisterstown Road Baltimore, MD 21215 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Carse (Final disease a Sudden Unexplained Death In Infancy xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial - tra Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me, g923 1-18-12 sm Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Month 3 Ectopic pregnancy Day Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ě 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sal director, page 2 should? 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? ✔ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 X No unknown Pending fd 8:23 am fd 11-3-11 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1606 McCullough St. Apt 3 baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be within 24 hours a **To the Funeral** determined Residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 4, 2011 30. Name an address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registra

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36495 Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ AUDREY H. ADAMS 12:40 AM November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Blue Point Nursing Home N/ABaltimore City Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral ^{Year)}1930 Hours July 31 1 M 2 X F Pennsylvania Director 81 204-26-8721 Usual Residence of Decedent -f show led at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/AMaryland **Baltimore** 1 X Yes 2 ☐ No must be note. or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21215 USA 2525 West Belvedere Avenue or items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: Specify: White 'natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Residence Homemaker Unkown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marguerite S. Stevenson John L. Heilman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 254 Stuart Road, Carlisle, Pennsylvania 17013 Dennis B. Gotthard (Friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOFFMAN ROIH F.H. 11/16/2011 | Carlisle, PA CREMATORY 21. Signature / Funera Se vio Licer any inj MITCHELL WILLEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, MD 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Pnysician/ Medical Cardiae arrythemias minules disease or condition resulting in death) Due to (or as a consequence of): Examiner Atherus claratic heart disease 5 425 Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Demention 1.7 Due to (or as a consequence of) resulting in death) Last physician dellusional disorder Physician/Medical 11 that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 16 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: မှ 4 Universing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-14-2011 D 30494 2000 大のころかり 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 716 Maiden Choice Lane, Suite 302, Baltimore, MD 21228 Kirtikant Desai, MD,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 6 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36496 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 79 N. Culver Street Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 214-88-9056 Director 1 - M 2 1 F 44 Sept. 25, 1967 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 79 N. Culver Street 21229 USA items ; death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ould be filed within 72 m and Mental Hygiene. Is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Psychologist Kennedy Krieger Inst. 4 Be Department of Health and Montal Hy Important: If item 27 is marked other any injury or other **-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theodore H. Brooks Christine A. Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 79 N. Culver Street Baltimore, Maryland 21229 Christine A. Jones - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 11/10/2011 Windsor Mill, Maryland King Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service in nsee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD. 21215 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) neumone Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year the 9 Unknown 9 🗌 Unknown P.O. ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has s certificate has director, page 2 autopsy perform 1 🗌 Yes Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **W** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending iours after death.

Ieral Director; Af Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title

Registrar

State

(Month, Day, Year)

ompleted cause of death (Item 23a) (Type

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 36497 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M Medical acility Name (if not institution, Examiner give street and number) 4c. County of Death Town, or Location of Reath MORE MEDILAL AUTIMORE CENTY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**M 2 □ F 220-50-0775 Months 5-8-1948 Hours MARYLAND **Director** 63 Yrs Usual Residence of Decedent 28a-f show 10b. County 10a. State death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits notified MD HARFORD FOREST HILL 1 Yes 2 No 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? must be Funeral items 23a 2013 HILLCROFT DRIVE 21050 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. "natural", or þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. 1 Yes 2 X No Specify: WHITE 3 Widowed 4 X Divorced Completed 1968 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) LARGE MOTOR REPAIR BETHLEHAM STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) **GEORGE** ပ S. BURT DOROTHY Ε. SMITH 19a. Informant's Name/Relationship (Type, Print)
CHRISTOPHER BURT/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2013 HILLCROFT DRIVE FOREST HILL, M 21050 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place GARDENS OF FAITH 4 ☐ Donation 5 ☐ Other (Specify) 11-16-11 BALTIMORE, 21. Signature of Funcial Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any country library cause. Enter Underlying Cause (Disease or iinjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 10 24a. Was an certificate has autonsy perform 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P Other: within 24 hours after deau..

To the Funeral Director: After this of the funeral director in by the funeral director. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continued Praction or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on 29b. Signature and 29d. Date signed (Month, Day, Year) 29° 6' CENS 104760 772081 MICICIAN Name and address of per eted cause of death (Item 23a) (Type, Print) GREENE STREET NOPOL 31. Date filed (Month, Day, Year) 32, Registrar's Sign ture State

DHMH 17 Rev 7/2009

Registrar

NOV 1

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and **Examiner** N/A <u>Baltimore</u> <u>Johns Hopkins Hospital</u> 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) Country) Months 216-32-9308 Director 1 🗷 M 2 🗆 F Feb. 2,1937 Yrs. Maryland 74 Usual Residence of Decede 10d Inside City Limits 10b. Count 10c. City, Town or Location 10a. State with the Maryland Director notified 1 Yes 2 X No 28a-f Mar vland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ö ms 23a or must be r Funeral 7860 West Riverside Road 21122 II.S death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black White etc. þ 1 Never Married 2 Married Yes 2 No "natural", or Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) er than the Me Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed N/A Electrician nt of Health and Mental Hygie t: If item 27 is marked other or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Emmerich Frederick Η. Bealefeld. Sr Edith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29803 Apple Drive Cordova, Maryland 21625 Charles E. Bealefeld (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 11/17/2011 Glen Burnie, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBRAL INFARCTS Onset and Death Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the at d be detached for 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Certificate: To Be Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🔲 No 28d. Describe how injury occurred Natural iniury 5 Pending Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifier CSMO

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Registrar

State

31. Date filed (Month, Day, Year)

NOV 1 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ARL Physician/ Medical 4a. Facility Name (if not institution, give street and number) of Death **Examiner** Baltimore Seasons Hospice at Northwest Hospital Randallstown Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea Social Security Numbe **Funeral** Months **Director** 219=30=9012 1 🗆 M 2 🕱 F Dec 25, 1933 Maryland 77 Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at Director Pasadena 1 Yes 2 X No Anne Arundel Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 21122 USA 1399 Amphibian Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No If Yes, Give Year or Dates Specify White Specify: 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) C & P Telephone Co. event, the Clerk 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file in and Mental H Rebecca Harrison Edward Moran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1399 Amphibian Drive, Pasadena, Maryland 21122 (Son) Glenn K. Brockmeyer 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 11/21/2011 Glen Haven Mem. Pk. 4 Donation , 5 Other (Specify) McCully-Polyniak Funeral Home, P.A. 21. Signature Ju Mervice Licensee 22. Name and Address of Facility Kevin E Ecker 3204 Mountain Rd., Pasadena, Md. 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached 1 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be det þ To the Hospital or Attending Physician: The law requires 2 No 3 Probably Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? 1
Yes 28d. Describe how injury occurred Certificate: 24 hours after death.
Funeral Director: After teely filled in by the funer injury Natural 5 Pending 2 No Investigation Accident Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Tpletely (Check within 2.

To the F
complet 29b. Signature and title 16 who completed cause of death (Item 200

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 2011 /Medical Name (If not institution, give street and number) 4c. County of Death Examiner NIA saltma Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 214-40-545 Days Months 1**9** M 2□ F 440 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Nes 2 No Baltimore Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shore man 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other tra altimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 18/2011 Other (Specify) ralto more 21. Signature of Funeral Service 22. Name and Address of Facility 2121 Itimae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Medical Due to (or as a consequence of) Examiner Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the b attending IF FEMALE for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ icate has been siç r, page 2 should b 2 No 3 Probably 4 Onknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Ves 2 No certificate has 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 2 ပ 1 🗌 Yes 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 2011

30. Name an

32. Registraris Signature

29c. License number 0006931 4

address of person who completed cause of death (Item 23a) (Type, Print) than Wood (2 Remarker MD 2 les 4

29d. Date signed (Month, Day, Year)